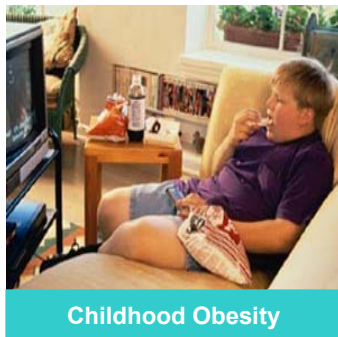


NASSAU COUNTY COMMUNITY HEALTH ASSESSMENT

2005-2010



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INTRODUCTION

Executive Summary

This is a report on the health of the County, but it is in fact several reports. It is, of course, a study of the County's 1.3 million persons in aggregate, and at this level Nassau is very healthy. For many important measures we are at historic lows (tuberculosis, measles) or highs (childhood vaccination coverage), and meet or exceed national *Healthy People 2010* goals. If we look beyond health measures, we see similar success in areas such as education, income and public safety.

However, there are substantial differences between the County as a whole and communities that contain its neediest residents. The health of these "selected" communities of Freeport, Hempstead Village, Inwood, Long Beach, Roosevelt and Uniondale, Westbury is poorer by almost every measure currently available. One community, Roosevelt, has the highest rates of AIDS, teenage pregnancy and sexually transmitted disease in the County, and among the highest in the state.

There are also differences in health status based on race and ethnicity. Infant mortality, cancer mortality and homicide rates are much higher for blacks than whites. Latinos have higher rates of teen pregnancies, tuberculosis and deaths from injuries. The causes of these disparities are numerous and complex, and include differences in income, education, housing, access to health care, as well as racism. Reducing or eliminating these disparities is one of the most important national and local public health goals.

This is also a report on priorities, goals and opportunities. Some are clearly evident in the tables and graphs: arresting the nascent rise in syphilis among men who have sex with men; reducing teen pregnancy (almost always unplanned); reducing rates of new HIV infection in minority women; and continuing efforts to reduce smoking and prevent non-smokers from starting. Other priorities have been identified at community forums, or in discussions with community leaders. These include improving access to care for the poor and uninsured and strengthening the public health capacity to respond to emergencies, (including bioterrorism). In each of these areas, we have identified opportunities, not only for the local health department (LHD), but also for the many public and private agencies, health care providers, and community-based organizations that comprise our public health system.

This year's Community Health Assessment has been reorganized and reformatted, first to be more readable, and second, to clearly identify what we believe to be the most important public health issues. We have also used color graphics and geographical information system (GIS) mapping for the first time. We have placed the complete report on our web site: (www.nassaucountyny.gov/official/county/agencies/Health), where we have included additional features including health reports on the county's three towns and two cities. In the coming months and years we hope to add additional detailed community level health data, because in Nassau County, the most important public health issues are best understood and tackled at the community or neighborhood level.

Notes on Methods and Data Sources:

The report makes use of standard assessment practices of collecting, organizing, analyzing and/or interpreting data to develop concise presentations, sometimes in graphic statistical formats, to bring clarity to each topic. The overall goal of the report is to assist in setting identifiable public health priorities, establishing goals, setting strategy, determining opportunities and measuring progress.

The report is based primarily on data sets from the New York State Department of Health, including the Bureau of Biometrics (Vital Statistics), Statewide Planning and Research Cooperative System (SPARCS), and disease registries for cancer, communicable disease, tuberculosis, AIDS/HIV and STD's. It also uses data from the New York State Department of Labor, New York State Office of Alcohol and Substance Abuse Services (OASAS), Behavioral Risk Factor Surveillance System (BRFSS) and the U.S. Census Bureau

Selected Communities are defined as those zip codes that were identified (using the NYSDOH AIDS Institute Community Need Index, NYS Perinatal Risk Assessment Indicators, the U.S. Census, data from the NYSDOH, NCDOH and NCDSS) to have disproportionately higher rates for many diseases and have adverse social and economic conditions.

More information regarding sources and definitions can be found in the *Glossary* and *Resources* sections of the *Appendix*.

Executive Summary

FOCUS ON DISPARITIES

There are substantial health disparities and inequities between racial and ethnic groups, and in different communities in Nassau County. Minority groups bear a disproportionate burden of illness and premature death.

- The difference in the infant death rate is decreasing but is still substantial. In 1993 it was 4 times greater in **non-Hispanic** blacks compared to **non-Hispanic** whites and in 2002 it was 2 times greater.
- The estimated prevalence of HIV in blacks is over 20 times greater than whites and 3.5 times greater in Hispanics than whites.
- On average, from 1982-2003 when compared to white women, the rate of AIDS diagnosed in black women was 13 times greater and 2 times greater in Hispanic women compared to white women. The rate in black men was 6 times greater and 1.5 times greater in Hispanic men then when compared to white men.
- The average homicide mortality rate from 1999-2002 in blacks was nearly 9 times greater than for whites.

Likewise, a disproportionate burden of illness and premature death is concentrated in certain communities.

- Infant death rates in the selected communities have been more than twice that of the rest of the county since 1980.
- The rate of Chlamydia infection in the selected communities is rising and in 2004 was more than 3 times the rate in the rest of the county.
- Although the disparity in the rate of gonorrhea has decreased, in 2004 the selected communities had rates 3 times greater than the rest of the county.
- The rate of HIV/AIDS is 4 times greater in the selected communities compared to the rest of the county.
- The average asthma discharge rate for 2000-2002 in young children (age 0 to 4) was 2.5 times greater in the selected communities (excluding Long Beach) compared to Nassau County as a whole.
- In 2000 the diabetes discharge rate in the selected communities on average was over 1.5 times greater compared to Nassau County as a whole.
- The overall 5-year incidence trend of childhood lead poisoning is decreasing; however the average incidence rate is double in the selected communities compared to the rest of the county.

Social and economic factors associated with poorer healthcare are more common in the selected communities and among racial/ethnic minorities.

- The average household median income is on average 22% less in the selected communities compared to the rest of the county.
- In Nassau County, the selected communities rank as the top seven communities requiring public assistance.
- 6 of the 7 selected communities rank high on the Community Need Index (see Appendix: Exhibit 1DEM 9) and are designated as high risk for adverse perinatal outcomes (see Appendix: Exhibit 1DEM 10).

On average, from 1993-2002:

- The percentage of black and Hispanic women initiating early prenatal care was 25% and 23% less than non-Hispanic white women, respectively.
- In the “rest of the County”, the percentage of women initiating early prenatal care is 23% greater than those living in the selected communities.
- The percentage of low birth weight births to black women is more than twice that of **non-Hispanic** whites and Hispanics.

HEALTH DISPARITIES BY RACE, 2002					
		WHITE	BLACK	ALL RACES	PROPORTIONAL DIFFERENCE (BLACK vs. WHITE)
Life Expectancy	All	79.6	75.7	79.6	1.0
	Male	77.2	72.0	77.2	0.9
	Female	81.8	78.5	81.8	1.0
All Causes of Death (Mortality)*	All	744.8	973.0	743.0	1.3
	Male	887.6	1238.2	886.2	1.4
	Female	641.7	826.2	641.8	1.3
Cardiovascular Mortality*		299.1	386.2	299.6	1.3
Cancer Mortality (All Cancer Sites)*		181.9	196.8	177.6	1.1
AIDS Mortality*		1.3	13.4	3.6†	10.6
Homicide Mortality*		1.5	14.1	NA	9.4
Infant Mortality†**		3.7	12.2	4.8	3.3

*Rates per 100,000 population age adjusted to the 2000 US standard population. **Rate per 1,000 live births. †Crude rate.

NASSAU COUNTY DEPARTMENT OF HEALTH
COMMUNITY HEALTH ASSESSMENT
2005 – 2010

Section I - POPULATIONS AT RISK

DEMOGRAPHICS

Brief History

Nassau County's origin can be traced back as far as 1643 when settlers from New England crossed the Long Island Sound to seek more land. Forty years later, New York State was divided into 12 counties. Long Island was made up of three of these (Kings, Queens and Suffolk). Queens County included western Long Island and two towns, which would eventually become Nassau County (Hempstead and Oyster Bay). During the American Revolutionary War, pro-revolutionists split from royalists in Hempstead to form the Town of North Hempstead. The decision in 1898, by the three towns, to secede from Queens County led to the founding of Nassau County on January 1, 1899. In 1910, the city of Glen Cove seceded from the Town of Oyster Bay and in 1922, the City of Long Beach followed suit by seceding from the Town of Hempstead¹.

Geography

Nassau County is made up of five subdivisions, which include three towns (Hempstead, North Hempstead and Oyster Bay) and two cities (Glen Cove and Long Beach). It lies between Queens County, a borough of New York City, on the west; and Suffolk County on the east. The county has a total area of 453 square miles. Almost 37% of the County, or 166 square miles, is water.

Population Size

In 2000, there were 1,334,544 people, 447,387 households, and 347,172 families living in Nassau County, making it more populated than 10 U.S. states². It is the 27th largest county in the nation and the sixth largest county in New York State. The size of the County's population has remained at the same level since 1960. Over the same period, New York State's population increased

by 13.1% and the population of the United States increased by 57%. While there has been some fluctuation in the County population during the forty year period (e.g., in 1970, the resident total climbed to 1,428,080 and in 1990 there was a decline to 1,287,348); the 2000 recorded census is a return to the 1960 level.

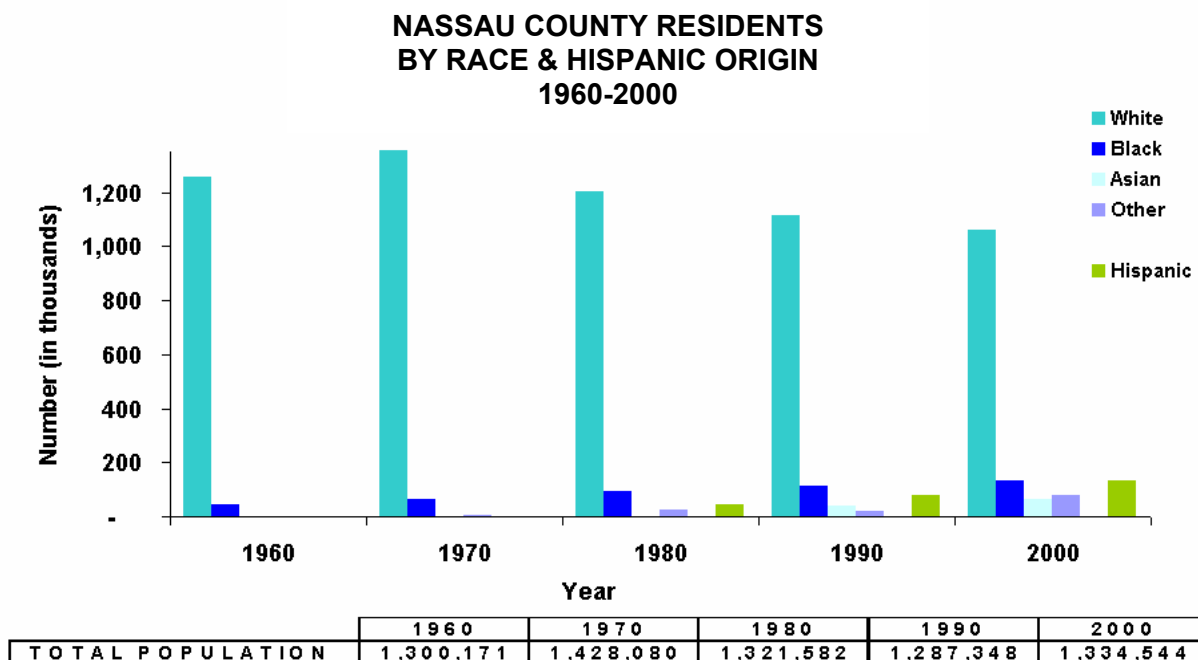
Population Characteristics

Nassau County is undergoing a rapid demographic shift, even as the total population has remained the same. The population is significantly older than it was twenty or even ten years ago, and it is becoming far more ethnically, racially and economically diverse. While the County ranks among the top 15 counties in the nation in terms of median household income³, the difference between affluent and poorer communities is pronounced (see Appendix: Exhibit 1DEM 8).

Race and Hispanic Origin

In 1960, when the U.S. Census began to classify race, blacks accounted for 3.3% of the total population and whites for 96.7%. By 2000, the non-white population had increased to 20.7% of the total, (blacks 10.1%, Asians 4.7% and "Other" was 5.9%). Individuals of Hispanic origin (of any race) accounted for 10.0% of the population. In the 40 years between 1960 and 2000, the number of white residents decreased by almost 200,000 or 15.9% (Figure 1), while the number of blacks increased from 42,320 to 134,673 (218%). In 1980 (the first census to record Hispanic origin) the number of persons of Hispanic origin in the County was 43,286. By 2000, twenty years later, that number had more than tripled to 133,282. The Asian population increased as well, from 40,941 in 1990 to 63,130 in 2000. Twenty-three percent of the population speaks a primary language other than English in the home.

Figure 1



Race is White, Black, Asian and Other. Other includes race not stated. Hispanic is counted separately from race. In 1960, White included all categories except Black.

Source: U.S. Census 2000

Age and Sex

In 1960, half of the County's population was under 30 years old but by 2000, the median age had

increased to 38. Seniors (aged 65 years and older) increased by 148% (80,847 to 200,841). Nassau County's population is older than either New York State or the U.S. on a whole. Fifteen percent of the residents

of the County were aged 65 years and older, compared to 12.9% for New York State and 12.4% for the U.S (Figures 2 and 3). The number of elder seniors (85 year and over) increased from 3,560 to 22,209 (524%).

In 1990, women outnumbered men in the total population by 7.0% (692,227 females vs. 642,317 males). Within the black population, the number of women exceeded that of men by 17.4% (59,969 vs. 51,088 males). By contrast, men of Hispanic origin outnumber their female counterparts by 4.1% (39,984 males vs. 38,422 females).

By 2000, there were 7.8% more women than men living in Nassau County, largely due to an increase in the number of

Figure 2

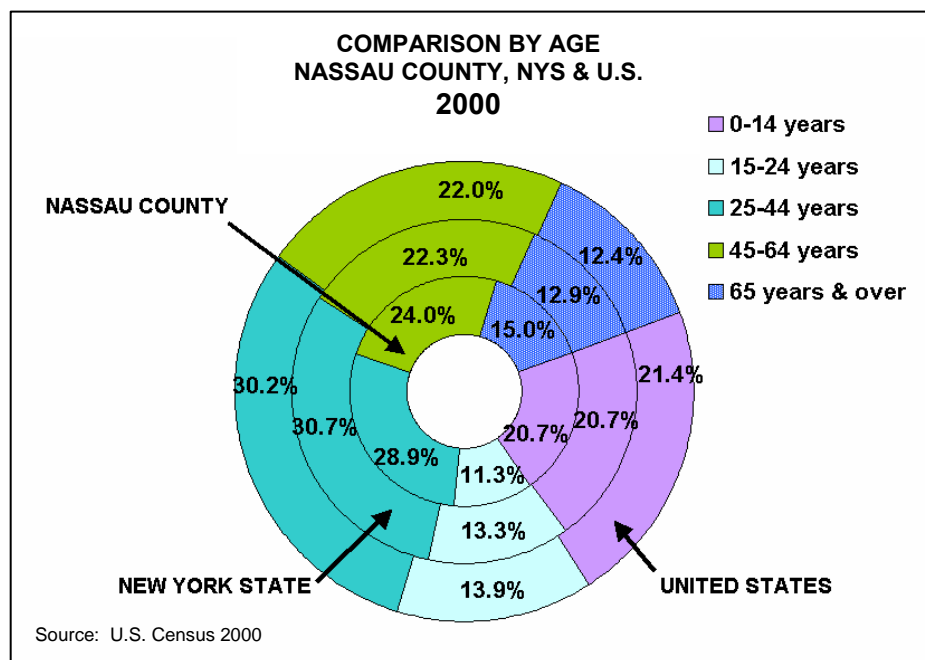
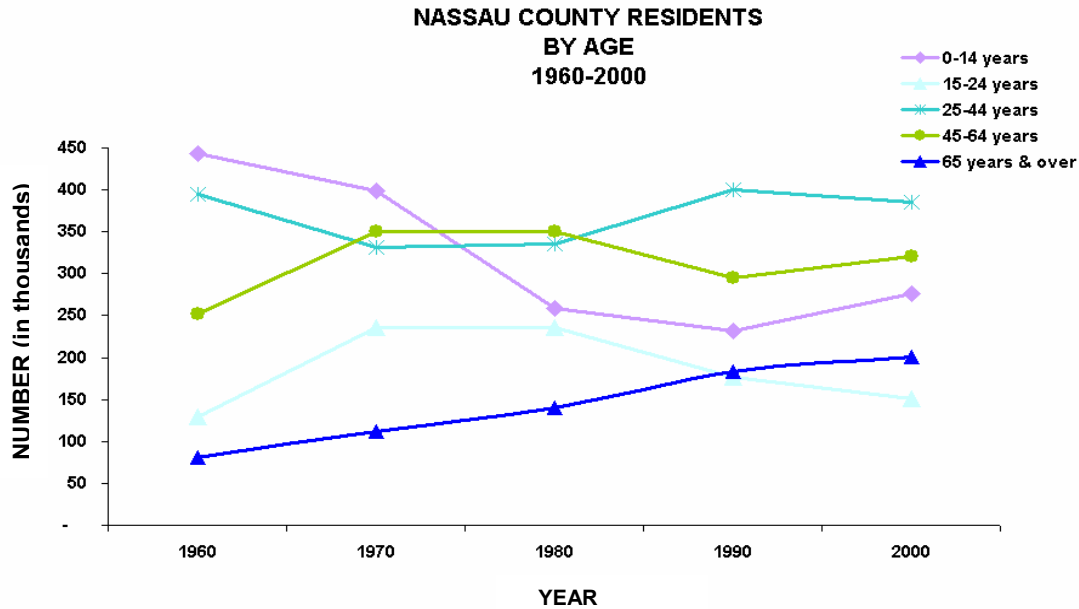


Figure 3



Source: U.S. Census, 1960, 1970, 1980, 1990 and 2000.

African American women versus their male counterparts (73,484 vs. 61,189, respectively). (See Appendix: Exhibits 1DEM 5, 6 and 7.)

Income

The median household income (in 2003 inflation-adjusted dollars)⁴ in Nassau County was \$80,647, placing it in the top ranking counties (6/3219) in the US and Puerto Rico (Table 1). The median household income has almost doubled since 1990, when it was

\$43,393. In New York State, the 2003 median household income was \$43,464 and in the U.S it was \$46,195.

The 2000 Census indicated that 5.2% of County residents (68,631, up from 12,936 or 3.6% in 1980) live below the federally designated poverty level (\$18,400).⁵

Employment

In February 2005, there were 650,500 people employed and 30,000 (4.4%) unemployed in Nassau County. Suffolk County, New York State and the United States had unemployment percentages of 4.8%, 5.6% and 5.8%, respectively⁶ in February 2005.

Educational Attainment

The percentage of high school graduates in Nassau County increased marginally from 84% in 1990 to 86.7%, in 2000. Residents with bachelor's degrees grew from 30% to 35.4% in Nassau County in the same time period. By comparison, 27.4% of New York State residents had bachelor's degrees or higher.

Housing

There are 447,387 households and 347,172 families living in 458,151 housing units in Nassau County (compared to 423,795, 355,437 and 434,151, respectively, in 1980). The housing density is 1,598 housing units per square mile. Fully, 73% (327,134) of the County's housing units were built prior to 1960.

**Table 1
2003 MEDIAN HOUSEHOLD INCOME
(Top 15 Counties in the U. S.)**

Geographic Area	Median Household Income	Rank
Somerset County, N J	89,289	1
Howard County, MD	88,555	2
Prince William County, VA	82,926	3
Morris County, NJ	82,025	4
Fairfax County, VA	80,753	5
Nassau County, NY	80,647	6
Santa Clara County, CA	76,544	7
Montgomery County, MD	76,439	8
Rockland County, NY	72,276	9
Collin County, TX	71,458	10
McHenry County, IL	70,956	11
Suffolk County, NY	70,281	12
Fairfield County, CT	70,083	13
Fort Bend County, TX	69,848	14
Contra Costa County, CA	69,835	15

Source: U.S. Census American Community Survey

HEALTH STATUS BIRTHS

Assuring the health of mothers and infants is significant to the public health mission. Infant mortality is one of the most important indicators of a population's health and one for which there are substantial social disparities. Low birthweight, poor nutrition and tobacco/substance abuse are independent risk factors for infant deaths and other adverse outcomes. Unintended pregnancies are also more likely to have poor outcomes.

Table 2
NASSAU COUNTY BIRTH PROFILE
(2002)

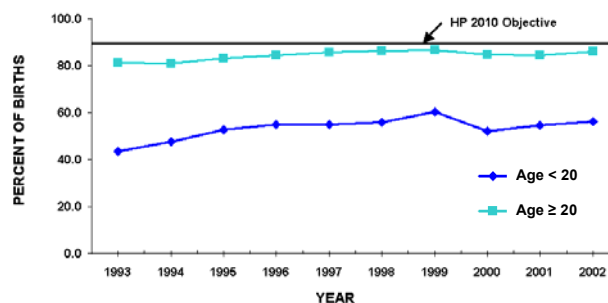
Characteristic	Nassau County	U.S.
Birth rate*	12.1	13.9
Fertility rate**	61.2	64.8
Low birthweight (<2500 grams)	7.6%	7.8%
***Early prenatal care	86.9%	83.7%
Births to unmarried mothers	18.3%	34.0%

*Births per 1,000 population. **Births per 1,000 women aged 15-44.
***Beginning in 1st trimester.

Prenatal Care

In 2002, almost 85 women out of 100 began their prenatal care in the 1st trimester (see Appendix: 2BIR 2). Among white, non-Hispanic women the number who sought care was 87 out of 100. Black, non-Hispanic and women of Hispanic origin are at 72% and 73%, respectively, (see Appendix: 2BIR 1).

Figure 4
TREND IN EARLY PRENATAL CARE BY MOTHER'S AGE
NASSAU COUNTY
1993-2002



Source: New York State Department of Health

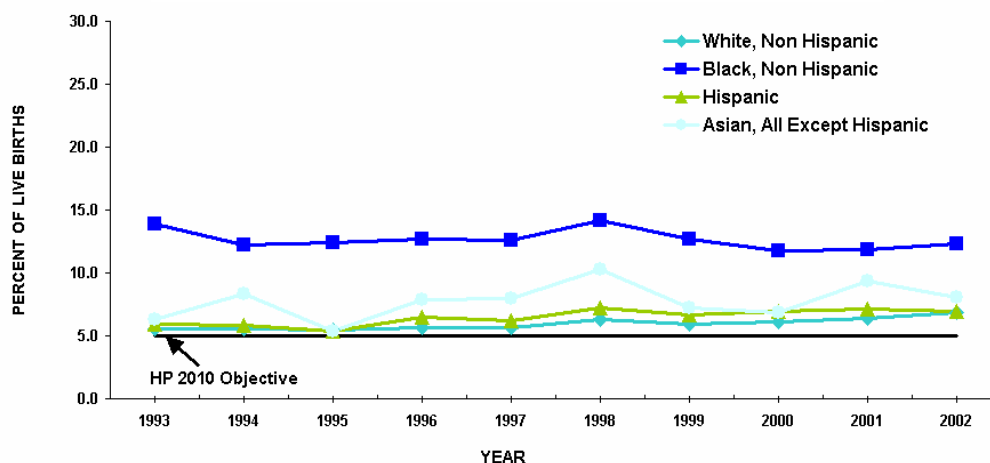
While there has been some improvement since 1993, only 56% of all women under 20, regardless of race or ethnicity, sought prenatal care in the 1st trimester (Figure 4).

Low Birthweight

Low birthweight infants are those who weigh less than 2,500 grams (5.5 lbs.) at birth. The Nassau rate (7.6%) is about the same as the State (7.8%) and the nation (7.8%) in 2002, but greater than Healthy People 2010 objective (5.0%). Black women and teenagers are at greater risk of having low birthweight babies than other women (Figure 5).

Figure 5

PERCENTAGE OF LOW BIRTHWEIGHT BIRTHS (<2500 GRAMS)
IN NASSAU COUNTY BY RACE AND HISPANIC ORIGIN
1993-2002



Source: New York State Department of Health

Infant Deaths

In 2002 the infant death rate for Nassau County fell below the healthy people 2010 objective of 5.0 per 1,000 live births to 4.8. However, the rate for black non-Hispanics remains high (12.8). It exceeds that of white non-Hispanics (3.4) by almost four times and doubles that of Hispanics (6.3), (Figure 6). Figure 7 shows the infant death rate by community. Infant death rates tend to be higher in the communities with greater numbers of black non-Hispanics, or the selected communities, (see Appendix: Exhibit 1DEM 8 and 10).

Hispanic women have birth outcomes comparable to white women despite being younger, poorer, less educated, and having less access to medical care. This "Hispanic paradox" in birth outcomes is not fully understood but may be related to better nutrition, less smoking and cultural factors related to community and family support.

Figure 7

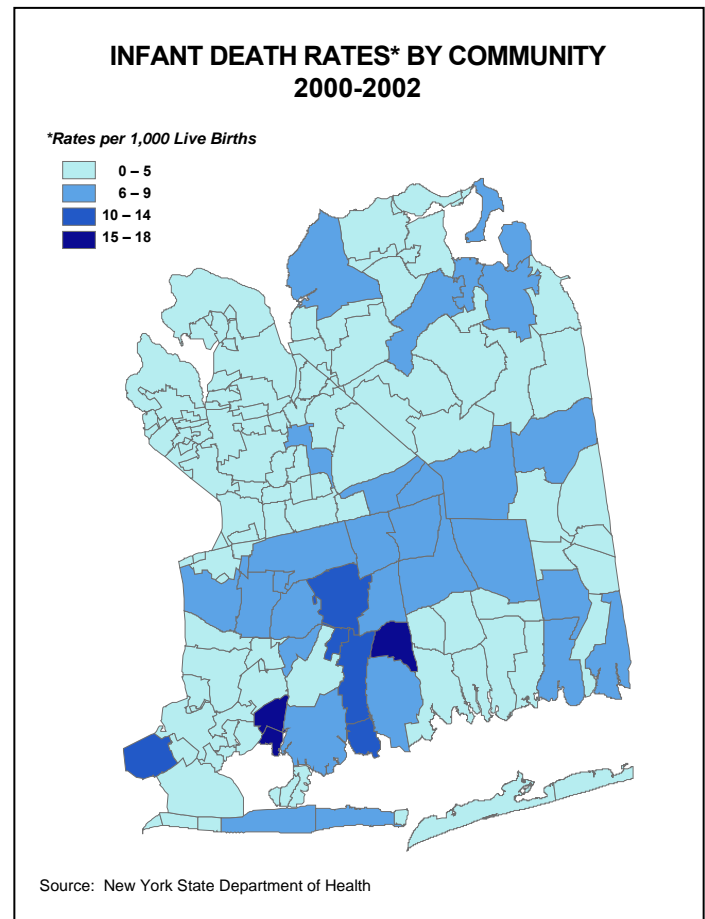
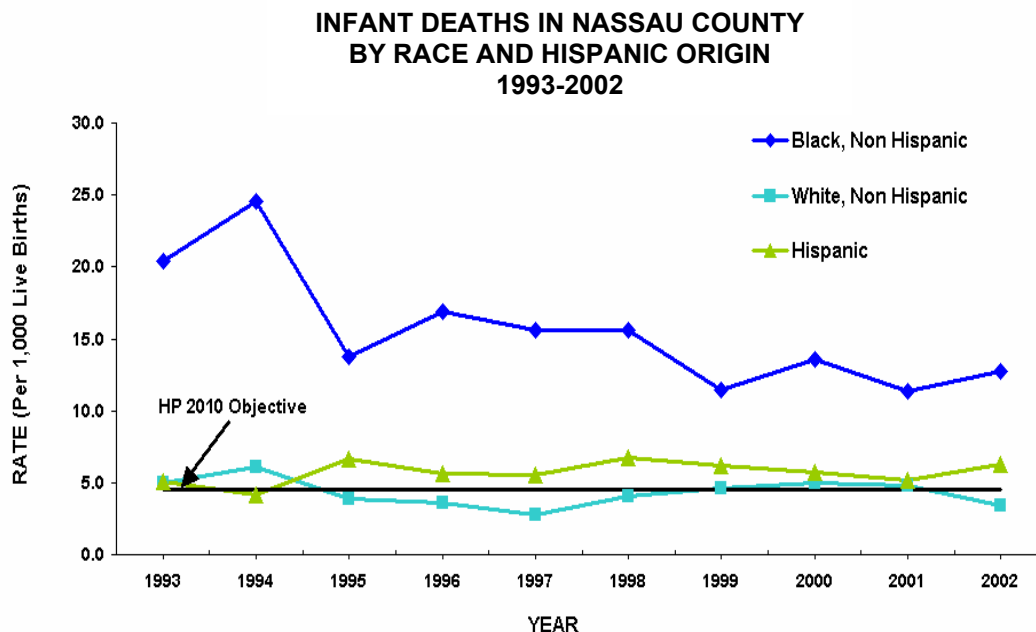


Figure 6



*Infant deaths occur in the first year of life. Rates are per 1,000 live births within the specified grouping.

Source: New York State Department of Health

FOCUS ON ■ Teen Pregnancy and Births

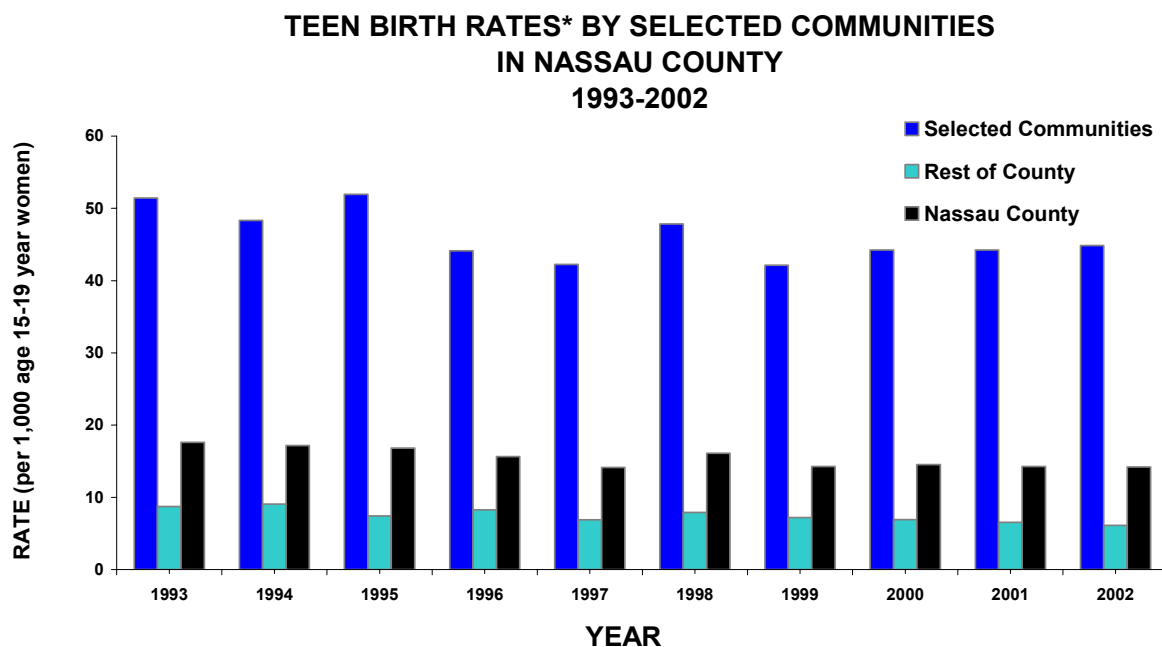
Adolescent sexual activity is extremely common. Nationally, two thirds of high school students reported having had sexual intercourse by the time they finished twelfth grade. This puts many teenage girls at high risk for unintended pregnancy and sexually transmitted infections, including HIV. Adolescent pregnancy and childbearing decreases the likelihood of completing high school, reduces employment opportunities and increases poverty and poor health outcomes for mother and child.

In Nassau County, there have been substantial reductions in teen pregnancies and births. Over a twenty year period from 1982 to 2002, the teen pregnancy rate decreased 51% (62.1 to 30.3) and in the past ten years the birth rate decreased 26% (18.4 to 13.7) (see Appendix: Exhibit 3TPFP 4). Abortions decreased 73%, but still account for 52% of all teen pregnancies.

While overall teen pregnancy and birth rates have declined, there are substantial racial, ethnic and socioeconomic differences in teen pregnancies and births in Nassau County. Teen birth rates are much higher in low-income communities and among minorities. The teen birth rate in the select communities was 44.9 per 1,000 teens in 2002 compared to 6.1 for the rest of the county (Figure 8). Teen pregnancy rates in 2002 were 76.2 in blacks, 67.8 in Hispanics and 21.5 in whites. In 2002, the birth rate in black teens was 35.4, in Hispanics 46.1 and whites 12.1. Teens in general are less likely to receive adequate prenatal care. Low birthweight, the greatest single risk factor for infant death, is highest in low-income communities and among teens.

The health and social implications of teen pregnancy are far-reaching. Teens are more likely to be diagnosed with a STD during pregnancy and their babies are more likely to be hospitalized and have childhood health problems. Later in life these children are at a higher risk for child abuse and for low educational and vocational achievement. Teen mothers are less likely to complete high school and more likely to have fewer employment prospects.

Figure 8



*Annual number of live births to women aged 15-19 per 1,000 female population aged 15-19.

Source: New York State Department of Health Vital Statistics.

HEALTH STATUS ■ EARLY CHILDHOOD

Immunization

Nassau County has very high immunization rates, even with the growing complexity of the recommended schedule (Figure 9). The County has almost no recorded cases of vaccine preventable disease (VPD) (see Appendix: Exhibit 4EC 3). Pertussis is the only VPD growing in prevalence, but this reflects change in diagnostic tests and surveillance. As a result of a change made in 2003 by the New York State Department of Health requesting that probable cases of pertussis be reported, the number of cases has increased reflecting probable and confirmed cases of pertussis.

Thimerosal and Vaccines

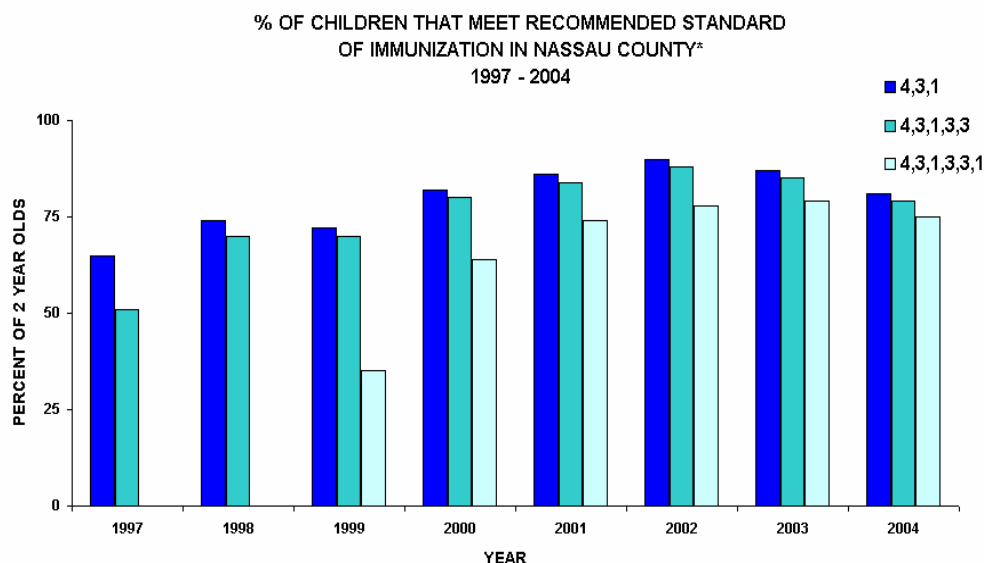
Vaccinations account for much of the decrease in childhood morbidity and mortality and are among the most effective public health tools. Recently, controversy has arisen regarding vaccine safety, particularly regarding the mercury-containing preservative thimerosal. Some groups have suggested that autism may be caused by the thimerosal found in many vaccines. The purported link between autism and vaccines has been studied in the United States and abroad. Thus far none of the studies have supported this

*connection. According to the CDC, the risks of thimerosal in vaccines have not been scientifically proven, whereas the risks of not vaccinating children on time are significant. Use of thimerosal in the production of vaccines has diminished; and "with the exception of some influenza vaccine, none of the vaccines used to protect preschool children against 12 infectious diseases contain more than trace amounts of thimerosal."*⁷

Asthma

In the 2003 Behavioral Risk Factor Surveillance System (BRFSS) survey, it was estimated that 16.4% of children in Nassau County households have been diagnosed with asthma and 11.8% had asthma at the time of the survey. Using hospitalizations as an indicator, it appears that asthma impacts the 0-4 year age group most severely. Hospitalizations for children between ages 0-4 averaged 400 per year for a rate of 33.5 per 10,000 population (compared to 55.1 for 1997-1999). Asthma hospitalization rates are higher in the selected communities for this age group (see Appendix: Exhibit 4EC 4). While hospitalization rates for children ages 0-4 are improving, the burden of asthma still exists. It is the leading cause of school absenteeism.⁸

Figure 9



4,3,1 = 4 doses diphtheria-tetanus-pertussis(dtp), 3 doses polio, 1 dose measles, mumps and rubella (mmr)vaccines. 4,3,1,3,3 = 4 doses dtp, 3 doses polio, 1 dose mmr, 3 doses Hep B, and 3 doses haemophilus influenza type B (Hib)vaccines. 4,3,1,3,3,1 = 4 doses dtp, 3 doses polio, 1 dose mmr, 3 doses Hib, 3 doses Hep B, and 1 dose varicella vaccine. In 1997 and 1998 Hep B and Hib were not measured because they were not part of the goal.

Source: Nassau County Department of Health Immunization Program.

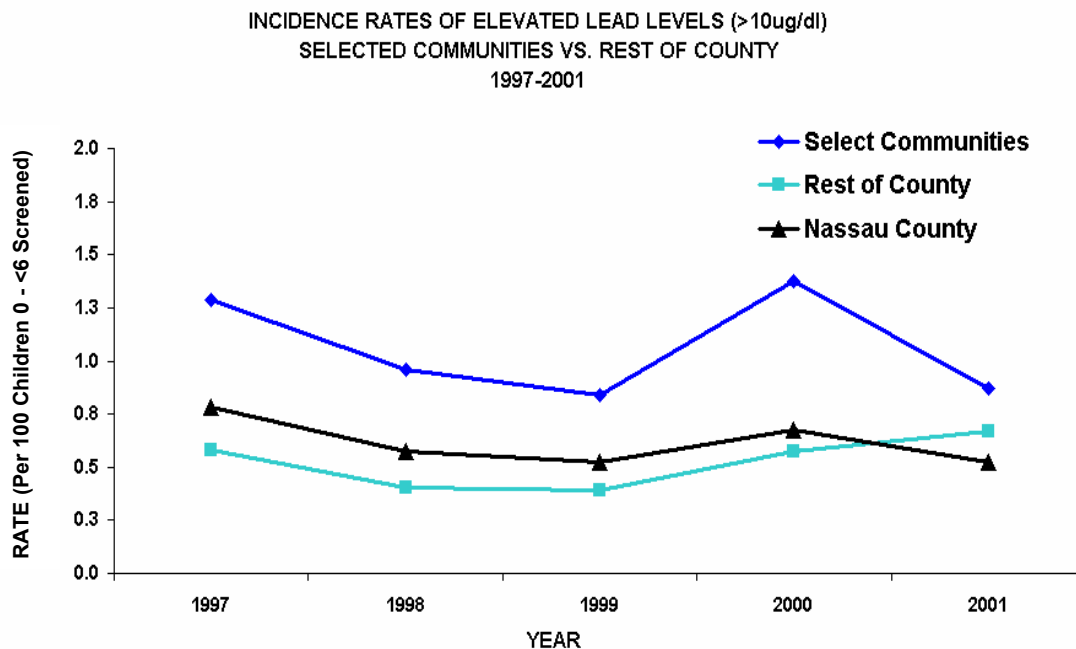
FOCUS ON Lead Poisoning

Rates of lead poisoned children have declined substantially in Nassau County. In the five-year period between 1997 and 2001, the number of lead poisoned children (blood lead levels $>10 \mu\text{g/dl}$) decreased 39%, and 49% in the selected communities (Figure 10). This improvement was due to the combined effects of parental education, lowering of maternal lead burden, and aggressive investigation by the NCDOH. A critical factor in the decline of blood lead levels both nationally and locally has been the decline in the number of homes with lead-based paint.

Nevertheless, lead poisoning remains a common serious condition of early childhood. In 2001, 155 children had a lead level $>10 \mu\text{g/dl}$, 22 children had levels $> 20\mu\text{g/dl}$. A lead level $>10 \mu\text{g/dl}$ may have long-term cognitive effects. Most cases are caused by ingestion of peeling, lead-based paint in housing built prior to 1960, when lead paint was outlawed. A growing percent of cases are caused by exposure to foreign cosmetics, herbal remedies, paints and other lead-containing products.

The New York State Department of Health's *Plan to Eliminate Childhood Lead Poisoning by 2010* focuses on (1) identifying and abating homes where children have been poisoned, (2) lead testing at ages one and two for all children, (3) education for all new parents about preventing lead exposures, (4) using prevention coalitions and intensive intervention to eliminate community-level disparities in targeted high-risk populations, and (5) increase activities associated with primary prevention that result in controlling potential lead hazards before a child is poisoned.

Figure 10



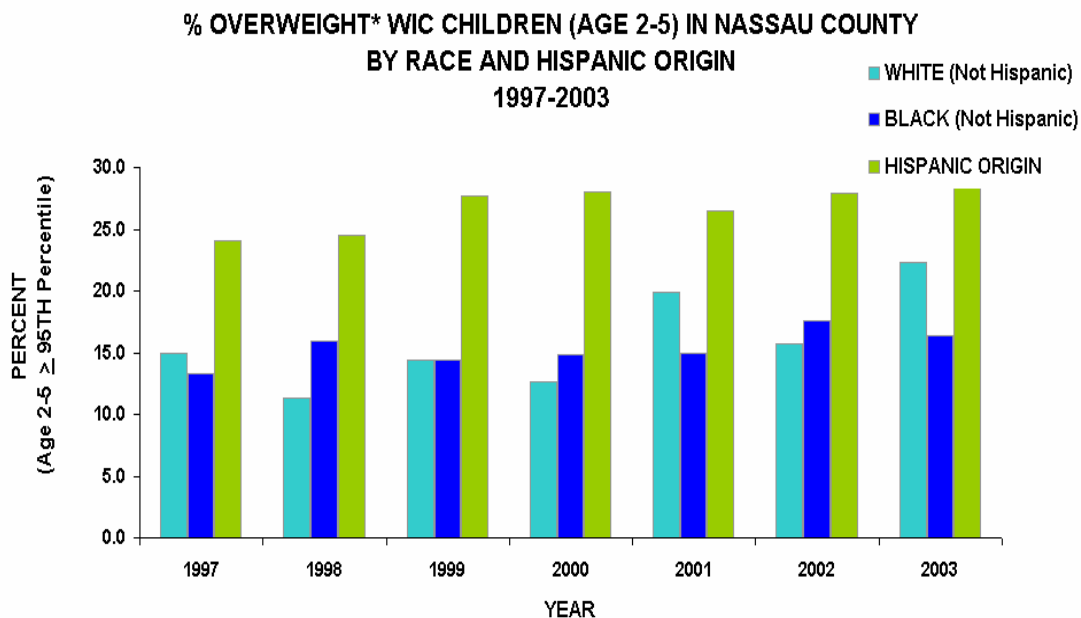
Source: New York State Childhood Lead Poisoning Prevention Program

Childhood Obesity

In New York State and Nassau County, there are no measurements of early childhood obesity except for the Special Supplemental Nutrition Program for Women, Infants and Children (WIC). In New York State, it is estimated that 16.1% of children age 2-5 years are overweight and another 16.1% are obese (BMI \geq 30). The 2003 CDC Pediatric Nutrition Surveillance Report identified the Nassau County

WIC program as having the highest percentage of overweight 2 to 5 year olds in the NYS WIC system. A total of 24.1% were overweight. White non-Hispanics were 22.3, black non-Hispanics were 16.4%; and Hispanics were 28.4% (Figure 11). According to a recently published report by *Trust for America's Health*⁹, New York State had the 3rd highest level for overweight low-income children, ages 2-5 and the 9th highest overweight high school student level.

Figure 11



*% Overweight = number of children >95th percentile Body Mass Index (BMI)-for-age divided by the number of individual records in the specified group.

Source: CDC Pediatric Nutrition Survey (PedNSS)

Oral Health

Dental caries is the most common chronic childhood disease¹⁰. The impact of tooth decay on a child's function to eat, speak, grow and learn led to the surveillance of 3rd graders across the country.

In 2002 and 2003, as part of a NYSDOH initiative,

the LHD oversaw completion of questionnaires and examinations on 309 third graders in nine Nassau County schools¹¹. Table 3 shows the differences found in the schools. children in lower socio-economic schools had poorer oral health and less access to dental care. For example, more than twice as many children had untreated tooth decay in low SES schools (36.2% vs. 17.8%).

Table 3
ORAL HEALTH OF 3RD GRADERS
NASSAU COUNTY vs. NEW YORK STATE
2002-2004

Indicator	Nassau County	NYS	Healthy People 2010 Objective
With caries experience			
All	50.4	51.3	N/A
High SES status	44.5	43.1	N/A
Low SES status	57.8	59.7	N/A
With untreated caries (tooth decay)			
All	25.6	31.5	21.0
High SES status	17.8	21.1	21.0
Low SES status	36.2	39.6	21.0
With dental sealants			
All	26.9	29.9	50.0
High SES status	32.3	41.3	50.0
Low SES status	20.0	19.6	50.0
With dental insurance			
All	65.7	80.3	N/A
High SES status	60.3	76.3	N/A
Low SES status	75.8	84.2	N/A
With at least one dental visit in last year			
All	84.2	73.5	N/A
High SES status	93.4	86.6	N/A
Low SES status	66.5	61.1	57.0
Reported taking fluoride tablets on a regular basis			
All	30.9	18.8	N/A
High SES status	37.6	29.7	N/A
Low SES status	16.9	10.3	N/A

SES is a measure of those eligible for free lunches or reduced-price lunches.
Source: NYSDOH

HEALTH STATUS ADULTS

One of the ten essential services of public health is the protection of the community from the threat of infectious or communicable diseases. In Nassau County, surveillance and timely intervention have contributed to a significant reduction in most of these diseases. (See Appendix: Exhibit 5AD 1).

Tuberculosis

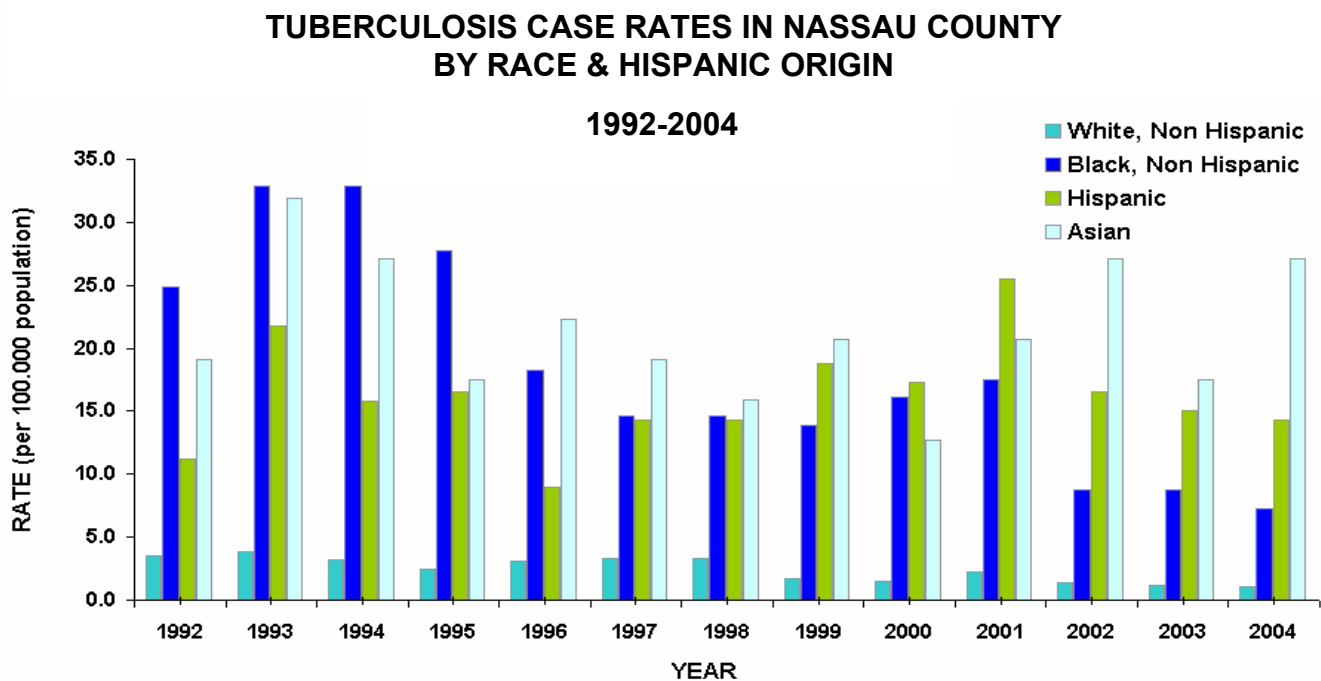
There has been a decrease in tuberculosis at the national, state and local level (see Appendix: Exhibit 5AD 12) but the rates still fail to meet the Healthy People 2010 objective of 1.0 per 100,000 population. The incidence of tuberculosis in Nassau County rose from a previous low of 5.4 cases per 100,000 population in 1986 to a peak of 10.3 in 1993 and then steadily declined to an historic low of 4.2 in 2003.

Tuberculosis rates are disproportionately higher among Asians and Hispanics. In the last decade, rates in Hispanics rose from 9.0 in 1996 to a high of 25.5 in 2001, but have since decreased to 14.5. Asians have had a consistently high rate of the disease, from 31.9 in 1993 to 27.1 in 2004. The rate among whites has not risen above 4.0 since 1992 (Figure 12).

The percentage of tuberculosis cases in foreign-born persons has steadily increased from 47% in 1993 to 74% in 2004 (see Appendices: Exhibits 5AD13 & 5AD 14).

Geographically, 38.5% of the total tuberculosis cases reported in 2004 were in the seven selected communities, while only 17% of Nassau's total population resides in these communities.

Figure 12



Source: Nassau County Department of Health

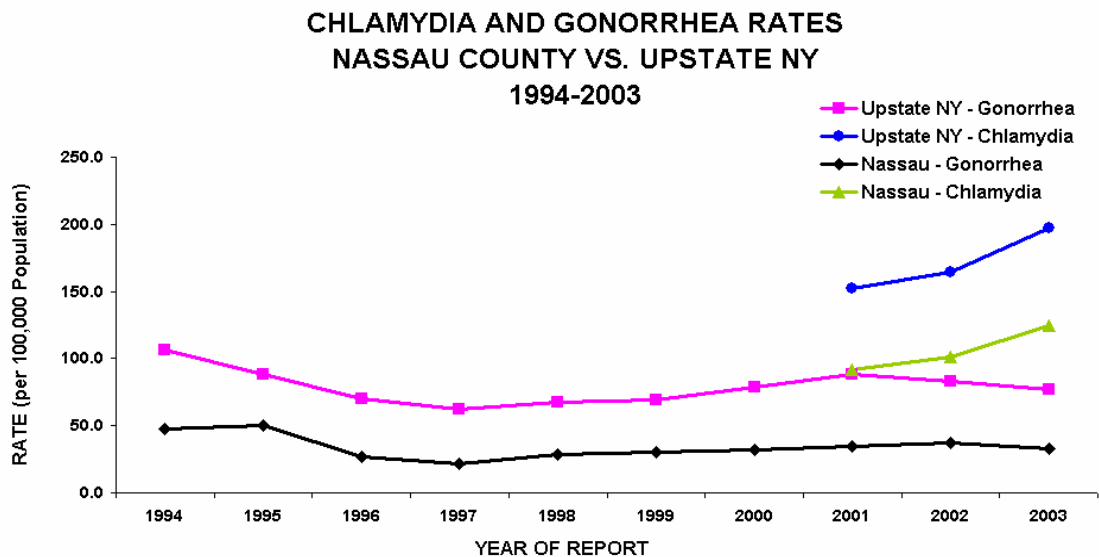
STD's

Gonorrhea rates in Nassau County have decreased from 47.6 per 100,000 population in 1994 to 32.7 in 2003. While all communities have shown decreases, the selected communities of the county, still have higher rates than Nassau County as a whole (see Appendix: Exhibit 5AD 15). STD rates, in general, are lower in the County than the rest of Upstate New York (Figure 13). Chlamydia, which became a reportable disease in New York State in June 2000, has seen an increase in rates from 2001 to 2003. This may be a

reflection of better diagnostic tests, testing guidelines and the availability of urine testing for women. The most dramatic increases have occurred in the selected communities (see Appendix: Exhibit 5AD 16).

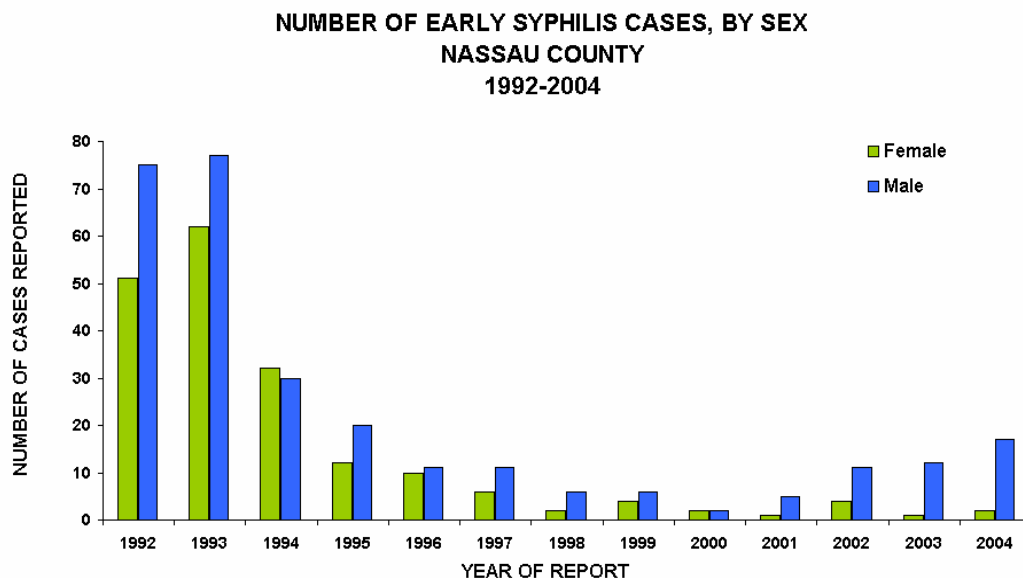
Early syphilis cases in Nassau County reached their height in 1993 during the region's crack epidemic when there were 62 cases in women and 76 cases in men (Figure 14). Syphilis cases decreased until 2001. The recent resurgence in early syphilis has disproportionately occurred in men who have sex with men.

Figure 13



Source: New York State Department of Health and Nassau County Department of Health

Figure 14



Source: New York State Department of Health and Nassau County Department of Health

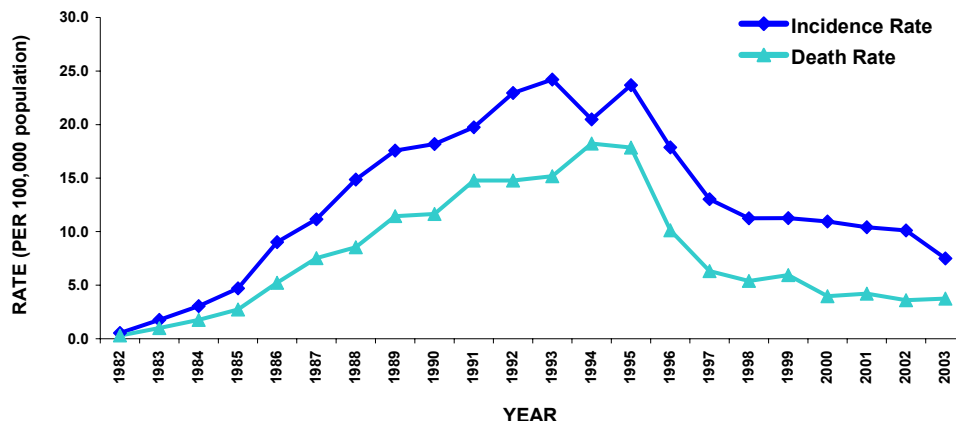
FOCUS ON HIV/AIDS

In Nassau County, AIDS first appeared as a disease of gay men, intravenous drug users and persons infected through blood products. AIDS cases increased steadily until 1995 when highly active anti-retroviral therapy (HAART) became widely available (Figure 15). Before HAART, the life expectancy (from the date of infection) for an HIV-infected person was estimated to be 12 to 14 years. Since HAART, life expectancy has increased.

Over the past 20 years the relative proportion of risk factors has changed (Appendix 5AD 17), as have the demographics of the epidemic. Even as AIDS rates decreased, the rate among women of color remained fairly stable, while the rate for white women decreased (Figure 16). By 2003, black women were over 30 times more likely to be diagnosed with AIDS than white women and over twice more likely than Hispanic women. Overall, AIDS and HIV infection are highly concentrated in the selected communities (Figure 17).

Figure 15

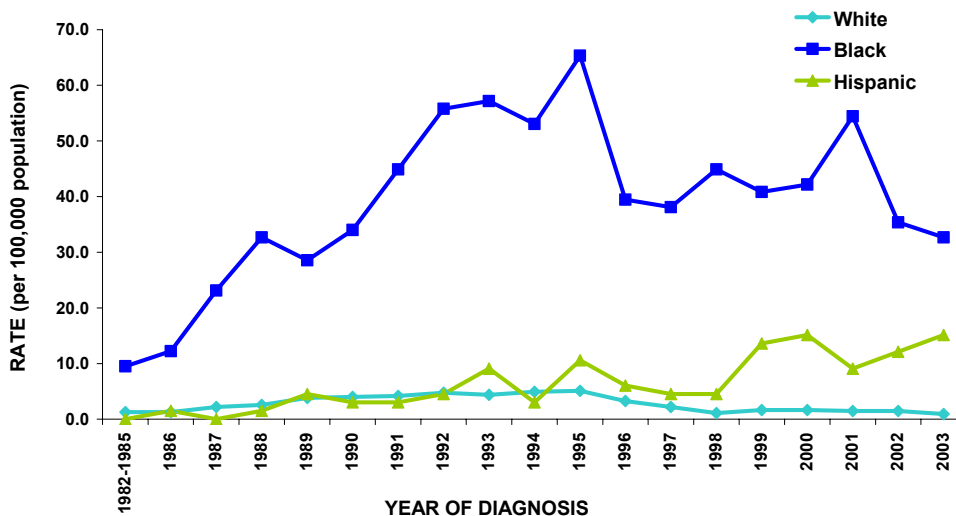
AIDS INCIDENCE AND DEATH RATES NASSAU COUNTY 1982-2003



Source: New York State Department of Health

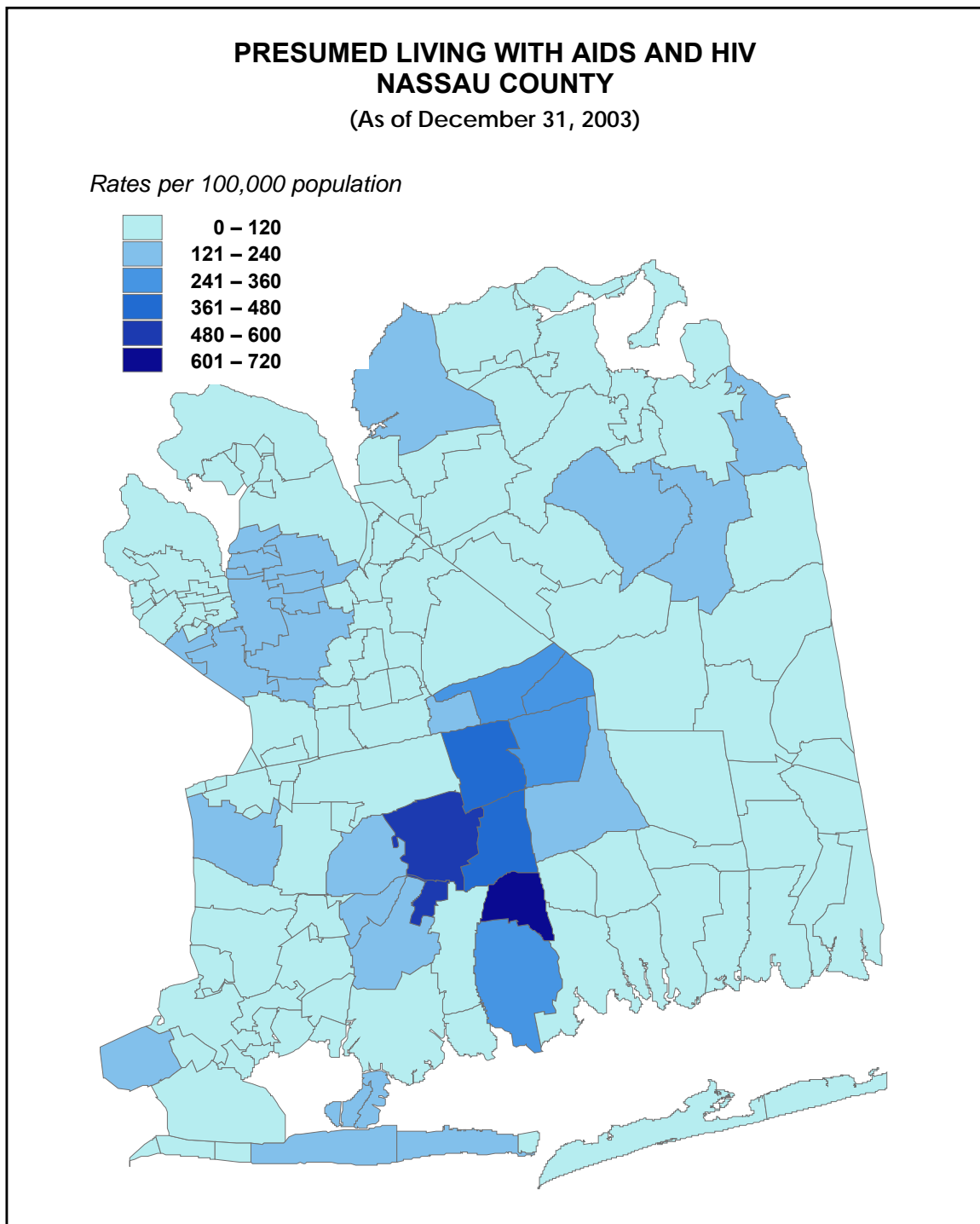
Figure 16

RATES OF WOMEN DIAGNOSED WITH AIDS IN NASSAU COUNTY BY RACE AND HISPANIC ORIGIN 1982-2003



Source: New York State Department of Health

Figure 17



NOTE: The cumulative data represents cases diagnosed through December 31, 2003. HIV reporting began in June 2000. Rates are based on 2000 Census population.

The New York State Department of Health (NYSDOH) indicates the following possible reasons for any discrepancy between the cumulative zip code information listed in this table and other tables that show a cumulative number of presumed living cases for 2002:

- 1) Zip code data does not include state prison inmates because the residence for inmates is based on the location of the prison rather than the person's usual address
- 2) Zip code data is not released when there are less than three cases for that zip code.
- 3) Many cases are reported without a zip code. In some instances zip codes may not even be available after surveillance is done on the case.

Source: New York State Department of Health

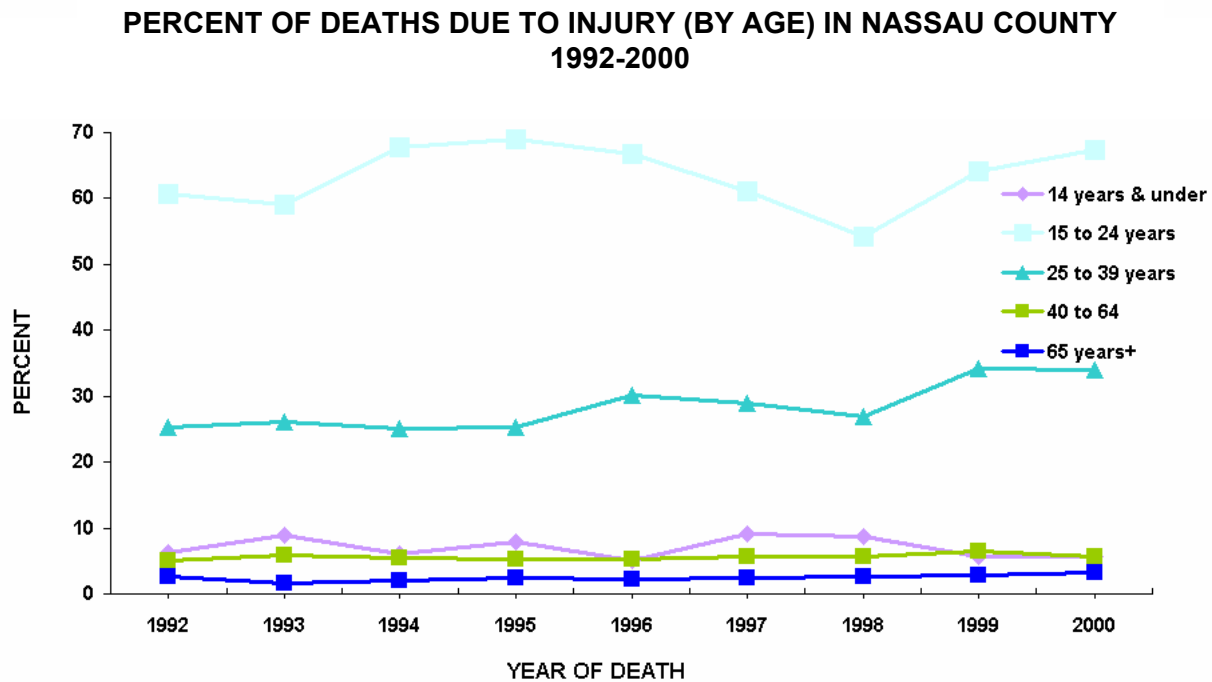
Injury

Injuries are an important cause of hospitalizations and deaths in Nassau County. The percentage of deaths due to injury is highest in 15-24 year olds followed closely by 25-39 year olds (Figure 18). From 1999-2001, motor vehicle traffic deaths were the leading cause of deaths due to injury in Nassau County for ages 10-24 year olds and 45-64 year olds and the second leading cause for 25-44 year olds and those 65 years and older. Motor vehicle traffic injuries were the leading cause of hospitalizations

for 15-44 year olds and the second leading cause for 5-14 year olds and all age categories 45 years and over.

The rate of hospitalizations due to self-inflicted/suicide injuries, from 1999-2001, was highest among 15-19 year olds and higher in females than males, however the death rate was highest in 20-24 year olds and in males. Hospitalizations and deaths due to assault/homicide injuries were highest in 20-24 year olds and higher males than females. (See Appendix: Exhibits 5AD 20, 5AD 21 and 7CHAI 10).

Figure 18



Source: New York State Department of Health

Cancer¹²

Cancer is the second leading cause of death in Nassau County. In 2002, the age-adjusted cancer death rate was 222.2 per 100,000 population, surpassed only by heart disease (295.0 per 100,000 population).

Deaths from cancer have decreased steadily in the County since 1976 (see Appendix: Exhibit 5AD 22). In men, the annual age-adjusted cancer mortality rate of 295.3 per 100,000 for the period 1976-1981 decreased to 222.2 for the period 1997-2001. In women, the rate decreased from 195.3 to 165.4. Lung cancer was the leading cause of cancer death in both men and women between 1997 and 2001. While there has been a substantial decline in lung cancer deaths in men (which can probably be attributed to the decreases in smoking rates over the last 20 years), female cancer rates increased from 1976 to 2001. There is some evidence that female lung cancer rates may be leveling off (Figure 19).

The second and third leading causes of cancer death in men were prostate and colorectal cancers. Breast and colorectal cancers were the second and third leading causes of cancer deaths in women.

The burden of cancer on selected communities can be seen best when the data are viewed by race (Table 4). In the period 1997-2001, black men were 22% more likely than white males to be diagnosed with cancer, primarily due to the higher incidence of prostate cancer in black men (309.6 per 100,000 in black men vs. 160.9 in whites). Black men also have higher incidence rates of lung cancer (91.6 vs. 80.7) and colorectal cancer (84.3 vs. 73.3). Black men were also more likely to die from cancer than white men. The most dramatic difference is seen with prostate cancer where the age adjusted death rate in black men was 69.3 per 100,000 vs. 25.7 for white males.

There is little difference in cancer mortality between white and black women (166.9 per 100,000 white

Table 4

AVERAGE ANNUAL SEX & AGE-ADJUSTED CANCER INCIDENCE & MORTALITY RATES NASSAU COUNTY VS. UPSTATE NEW YORK, BY RACE 1997-2001

SITE	RACE											
	WHITE				BLACK				ALL*			
	NASSAU		UPSTATE NY		NASSAU		UPSTATE NY		NASSAU		UPSTATE NY	
	#	RATE	#	RATE	#	RATE	#	RATE	#	RATE	#	RATE
ALL SITES												
MALES												
Mortality	1,271	220.5	11,061	246.3	101	275.2	724	315.1	1,397	222.2	11,876	248.1
Incidence	3,411	575.7	27,061	579.7	285	702.1	1,711	651.8	3,814	583.2	29,443	587.5
FEMALES												
Mortality	1,318	166.9	11,091	174.2	107	169.3	648	184.3	1,447	165.4	11,826	173.9
Incidence	3,481	471.9	27,243	456.6	252	381.8	1,406	379.7	3,849	461.7	29,271	453.7
LUNG												
MALES												
Mortality	349	59.3	3,345	72.5	28	63.1	225	91.0	383	59.5	3,594	73.0
Incidence	481	80.7	4,286	91.7	39	91.6	284	109.6	528	80.8	4,615	92.3
FEMALES												
Mortality	318	39.9	2,731	43.7	22	34.8	138	38.9	343	39.0	2,885	43.1
Incidence	465	59.7	3,768	61.7	27	42.7	182	50.7	498	57.4	3,991	60.8
PROSTATE												
Mortality	139	25.7	1,188	29.1	16	69.3	112	65.5	156	27.0	1,303	30.3
Incidence	979	160.9	7,507	158.6	124	309.6	649	258.6	1,148	171.7	8,438	166.7
BREAST												
Mortality	232	30.5	1,785	28.8	22	32.4	117	31.6	258	30.3	1,916	28.9
Incidence	1,056	148.5	8,110	140.4	75	105.8	400	103.4	1,172	144.3	8,729	139.0
COLORECTAL												
MALES												
Mortality	142	24.7	1,217	27.4	11	29.2	72	31.9	156	25.0	1,297	27.5
Incidence	430	73.3	3,445	75.1	33	84.3	175	70.4	477	74.3	3,685	75.2
FEMALES												
Mortality	133	16.1	1,272	18.9	13	21.8	71	20.8	148	16.3	1,351	18.9
Incidence	438	55.2	3,522	54.9	34	55.6	181	51.7	484	55.1	3,763	55.0

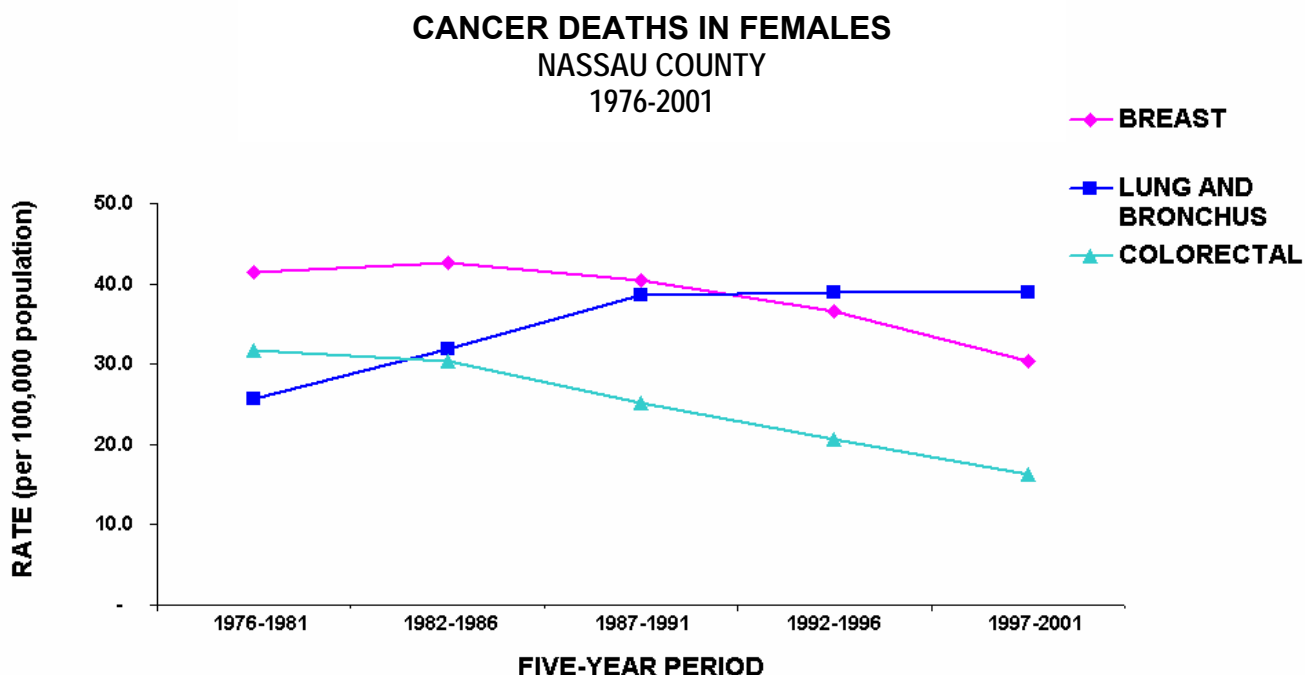
*Includes all other races, unknown and not stated. # equals the average annual cases (rounded to the nearest whole number) for the specified period, 1997-2001.

Source: New York State Department of Health Cancer Registry

females vs. 169.3 for black females). White females were more likely than black females to be diagnosed with a cancer, but this is likely a function of higher screening rates, especially for breast cancer. In two of the leading cancers, the death rates for black females were higher while the incidence rates were lower than in white females. For breast cancer, the death rate for black females was 32.4 per 100,000

vs. 30.5 for white females; even though the incidence rate in white females was 40% higher than that of black women (105.8 blacks vs. 148.5 whites). In colorectal cancer, the death rate was 35% higher for black women than their white counterparts while the incidence rates were almost the same (55.6 black women vs. 55.2 white women).

Figure 19



Source: New York State Department of Health Cancer Registry

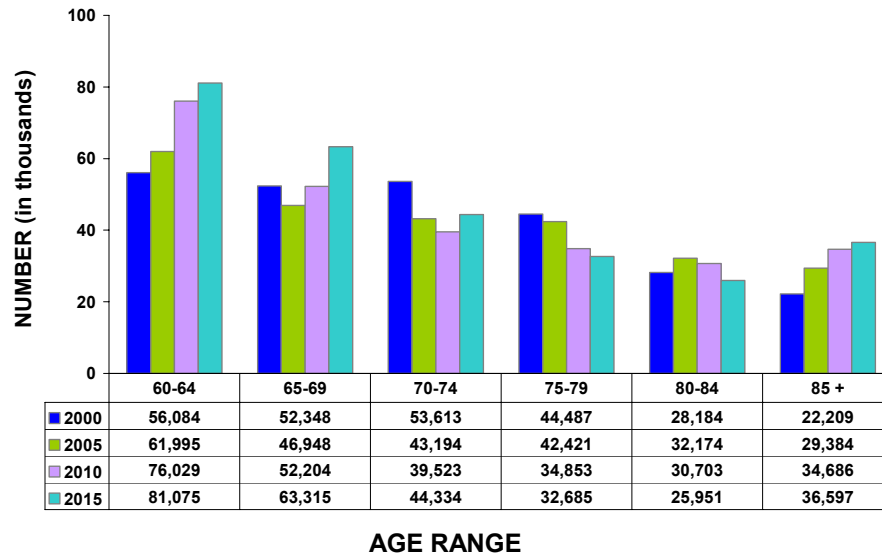
FOCUS ON AGING

Nassau County, like much of the United States, is getting older. From 1990 to 2000, the senior population (aged 65 years and older) increased from 182,899 to 200,841, and proportionately, from 14.2% to 15.0% of the county's population. The change in the racial and ethnic composition of seniors mirrors that seen in the total population of the county (Table 5). The United States Census expects this trend to continue. Projections through 2015 indicated that this group would grow to 202,882 with the 85+ population increasing by 65% to over 36,000 (Figure 20).

An aging population will put new and increased burdens on health and social service providers. Rates of physical and cognitive disabilities are highest among the elderly and increase with age (Figure 21). The elderly living at home will demand a variety of services (meals, home health aids) and a greater proportion will move into assisted living housing and long-term care facilities. As the life expectancy of the very old increases, the health care system will have to adapt to the greater prevalence of chronic illnesses including cancer, coronary artery disease, arthritis and dementia. While much of this care will be paid for by Medicare and personal savings, Medicaid is the primary payer for long-term nursing care.

Figure 20

**SENIOR POPULATION PROJECTIONS BY AGE GROUP
NASSAU COUNTY
2000-2015**



Source: NYSIS Populations Projections: <http://www.nysis.cornell.edu> and NC Senior Citizen Affairs

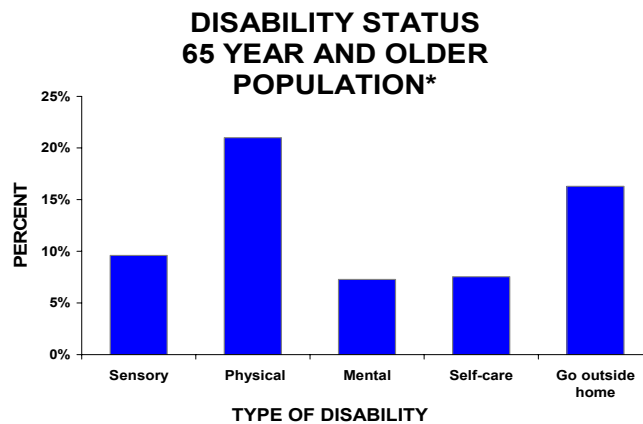
Table 5

**60+ POPULATION IN NASSAU COUNTY
BY RACE AND HISPANIC ORIGIN, 1990-2000**

Race/Ethnicity	1990	2000	% Change
White	244,578	230,385	-- 5.8
Black	11,158	16,020	+ 43.6
Asian	2,742	6,140	+ 112.0
Hispanic Origin	6,080	9,024	+ 48.0
Total Population	259,520	256,925	-1.0%

Source: U.S. Census

Figure 21



Source: U.S. Census

HEALTH STATUS HEALTH BEHAVIORS

Leading Causes of Death

The number of deaths in Nassau County has been at the same level for the past ten years. In 2002, reported deaths equaled 11,307 (vs. 11,296 in 1993.) The age-adjusted death rate (which shows what mortality levels are when no change occurs in the age composition of the population, over time) was 743.0 per 100,000 population (using the U.S. 2000 Census standard population) compared to 845.3 for the U.S. By race, the rate for whites was 744.8 vs. 973.0 for blacks. The death rate for blacks exceeded that of whites by a ratio of 1.3, which means that the risk of death for blacks is 31% higher than that for whites (Figure 22). These rates parallel those of the nation: the white population is 829.0 and the black population is 1,083.3, per 100,000 for a ratio of 1.3. The age-adjusted death rate for those of Hispanic origin was 704.3, compared to 629.3 for the entire nation. (A full discussion of differences by race and Hispanic origin in Nassau County can be found in the section FOCUS ON: Disparities.)

Table 6

2002*
DEATH RATES BY RANK
(Age-adjusted to the U.S. 2000 Standard Population)

Causes of Death	Nassau County	NYS	U.S.
Heart Disease	295.0	283.6	240.8
Cancer - Male	222.2	238.6	238.9
Cancer - Female	165.4	167.4	163.1
CVD**	29.3	38.4	56.2
CLRD***	28.4	34.8	43.5
Unintentional Injury	22.1	21.5	36.9
Diabetes Mellitus	11.7	19.7	25.4
Suicide	5.2	6.6	10.9
Cirrhosis of Liver	5.0	7.2	9.4
AIDS	3.1	10.9	4.9
Homicide	2.7	5.0	6.1

*Nassau County & NYS rates are the average of 2000-2002 deaths.

**Cerebrovascular Disease (stroke).

***Chronic lower respiratory disease.

Source: National Center for Health Statistics and NYSDOH

Figure 22

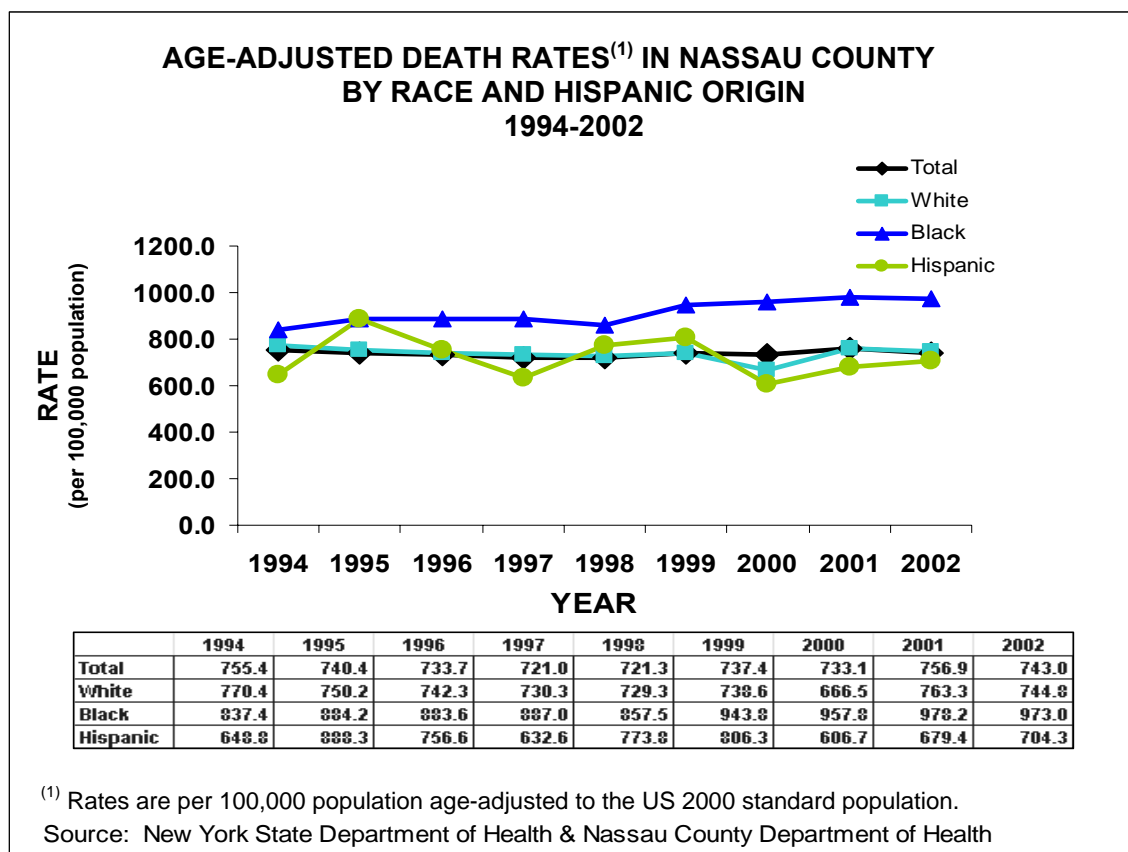
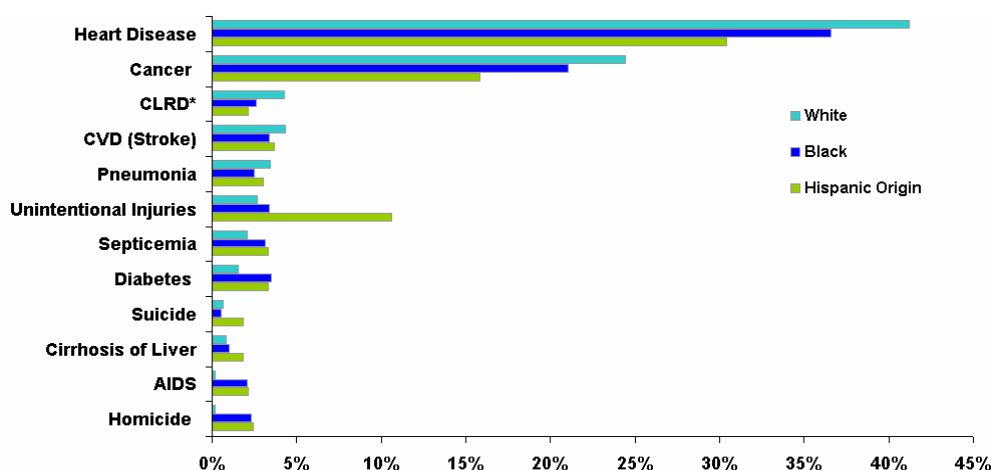


Figure 23

LEADING CAUSES OF DEATH BY RACE AND HISPANIC ORIGIN
NASSAU COUNTY
2002



*Chronic Lower Respiratory Disease

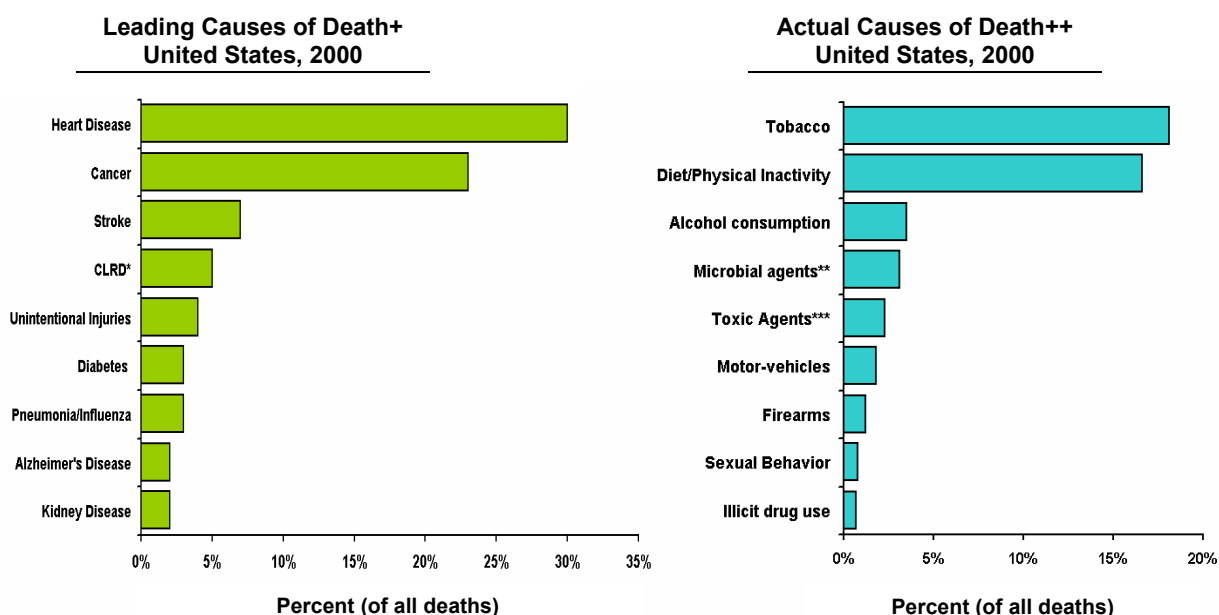
Source: New York State Department of Health

When one looks at the underlying social, behavioral and environmental causes of death, a different picture emerges. For example, almost 20% of U.S. deaths can be attributed to tobacco use, and its effect on the heart, lungs, vascular and other organs. According to the Centers for Disease Control (CDC), the most common actual causes of death in the United States in 2000

were tobacco (435,000), poor diet/physical activity (400,000), alcohol consumption (85,000), microbial agents, i.e. - influenza and pneumonia, (75,000), toxic agents, i.e.- pollutants and asbestos, (55,000), motor vehicle accidents (43,000), firearms (29,000), sexual behavior (20,000) and illicit drug use (17,000) (Figure 24).

Figure 24

LEADING CAUSES VS. ACTUAL CAUSES OF DEATH IN THE UNITED STATES



*Chronic lower respiratory disease. **Examples include influenza, pneumonia, etc. ***Examples include pollutants and asbestos.

+McGinnis JM, Foege WH; JAMA 1993; 270(18): 2207-12

++Mokdad AH, Marks JS, Stroup DF, Gerberding JL. Actual causes of death in the United States, 2000. JAMA. 2004; 291(10): 1238-1246

Smoking and Tobacco

More than 440,000 premature deaths occur each year as a result of smoking, the leading cause of preventable death in the United States. Smoking is a major risk factor for many of the most common causes of death, including heart disease, stroke, cancer, lung and vascular diseases to tobacco use. The National Center for Health Statistics has reported that in 2002, an estimated 22.5% of all adults in the United States were actively smoking. Nationally, 25.2% of all men and 20% of all women were “current smokers”.

In New York State 20.3% of all adults reported being “current smokers”.¹³ The proportions of male and female smokers are closer than the national percentages, 21.8% of men and 19% of women. Within the racial and ethnic groups, 21.6% of the whites, 20.7% of the black population and 15.9% of those of Hispanic origin were “current smokers”.

It is estimated that in Nassau County 17.7% of adults surveyed reported are “current smokers”, including 18.7% of women and 16.9% of men. 57.6% of the “current smokers” reported having attempted to quit.

Obesity

The Centers for Disease Control (CDC) indicated in 2004 that the factors of “poor diet and physical inactivity” that contribute to overweight and obesity rose by 33 percent over the past decade and may soon overtake tobacco as the leading preventable cause of death¹⁴ in the United States.

In Nassau County, the proportion of overweight and obese (BMI >25) persons more than doubled, from 1994¹⁵ to 2000-2002, from an estimated 24% to 52%, respectively. At the same time, approximately 76% of the adult population in Nassau County “participated in leisure time physical activity or exercise during the last 30 days” (see Appendix: Exhibit 7CHAI 6).

HEALTH STATUS ACCESS TO CARE

Access, according to the Institute of Medicine, is “the timely use of personal health services to achieve the best possible health outcomes”¹⁶ and assuring access to care is an essential public health service. In Nassau, access is dependent on many factors, including finances, having health insurance, transportation and available physicians. It is also dependent on having a health care system that can accommodate and respond to a population that is becoming more and more diverse. Increasingly, Nassau needs providers that accept Medicaid as well as reduced payments for the poor, speak many languages, understand different cultures, and recognize the effects of social conditions on a patient’s health.

Healthcare Providers

In 2004, there were 7,988 registered licensed physicians, 732 physician’s assistants, 965 nurse practitioners and 1,988 licensed dentists in Nassau County according to the New York State Education Department. (County numbers reflect the licensee’s primary mailing address, which may or may not be the licensee’s office practice address).

There are 12 hospitals in Nassau County with a 4,531 bed capacity. The combined admissions, in 2003, were 198,612 and the number of ER visits was 427,348. The Nassau Health Care Corporation (NHCC), parent company of the Nassau University Medical Center, provides additional health care services through its seven health centers; five full service community centers, one satellite and one school based clinic. The NHCC health center sites are located in the selected communities and draw patients from those communities (see APPENDIX: Exhibit 6LPHS 1,2 and 3).

The New York State Department of Health lists 35 available nursing facilities with a total of 7,919 certified beds in Nassau County, as of 2004 (see Appendix: Exhibit 6LPHS 5&6).

Access to Providers

Through a combination of “safety net” provisions within the **public health system** (including Medicaid and Medicare, Child Health Plus, Family Health Plus, other NYS insurance plans, not-for-profit hospitals and clinics, and private “pro-bono” care), many Nassau County residents are able to obtain medical care.

However, lack of insurance or underinsurance remains a major problem for many of the poor and middle class. There is no accurate count of the number of Nassau residents without health insurance. While 434,372 residents were enrolled in an HMO in 2003, the number of residents with other insurance can only be estimated. In 2003, the U.S. Census estimated that 15.5% of all people in the nation were uninsured. Using the same percentage for Nassau County, the number of uninsured would equal more than 200,000. (In the same year, the Nassau County comptroller’s office estimated that there were more than 300,000 who were uninsured or underinsured for prescription drugs.)

U.S. Census estimates show higher percentages of blacks and Hispanics are uninsured, nationally 19.4% of all blacks and 32.7% of all Hispanics. In NYS, it is estimated that 17% of the State’s 18-64 year old population has no health insurance coverage and the percentage of uninsured blacks is 20.0% and Hispanics 36.8% (see Appendix 7 – Community Health Assessment Indicators).

The uninsured of Nassau County include the working poor who are not eligible for “safety net” insurance plans and a growing number of undocumented immigrants and homeless persons who may have no mechanism at all for accessing health care. The consensus among community leaders is that these numbers are growing.

Financial Barriers

First and foremost, there are financial barriers to accessing care. Although the County has one of the highest median household incomes, many residents live in poverty. In 2003, 92,319 persons in the County were eligible for Medicaid. Significantly, 47% (50,906) of the County’s Medicaid eligible residents lived in the seven selected communities (see Appendix: Exhibit 1DEM 12).

In Nassau, access to private physicians improved with the advent of the Child Health Plus and Medicaid managed care programs, but many beneficiaries still rely on episodic emergency room or clinic care. There are relatively few

options for subsidized care (NHCC's community health centers and teaching clinics, residency clinics at many of the other hospitals, Planned Parenthood). The Nassau Partnership for Healthy Communities (NPHC) is working to improve access to private practice medical specialists.

Structural Barriers

Transportation is a structural barrier. There is a lack of adequate public transportation for the County in general. There are relatively few routes, and bus schedules are infrequent. Families without an automobile may be effectively barred from accessing medical services other than the NHCC Health Centers which are located in the selected communities. Hospitals are located throughout the County, but most are not located in low income communities.

Personal Barriers

The 2000 U. S. Census verifies that Nassau County has a large number of foreign born residents (18%) compared to the United States as a whole (11%). Immigrants, especially undocumented also face language barriers when entering the health care system. Either or both factors can result in the individual not getting treatment when it is needed. Lack of access to care can facilitate spread of infectious disease in the community (see Appendix: Exhibit 5AD 13 and 5AD 14).

Initiatives to Address Access Barriers

Some of the major initiatives being taken to address the barriers to access In Nassau County are:

1. Enactment of a hospital charity care ordinance, (passed in 2002) that assures "emergency inpatient or outpatient medical care, including ancillary services, to a person who is uninsured" and meets all qualifications.
2. County support of the Nassau Health Care Corporation (a public benefits corporation), which operates community health centers located in the selected communities.
3. Community-wide education and intervention strategies that address smoking, obesity and asthma.
4. Issuance of a countywide affinity discount drug card.

5. Active involvement in county and regional coalitions that address the needs of the uninsured and underinsured, in particular the Nassau Partnership for Healthy Communities, a Healthy Communities Access Program (HCAP). The major initiatives include:

- a. Community outreach and facilitated enrollment into qualified insurance plans.
- b. Increased access to primary care.
- c. Assurance of linguistically/ culturally qualified service.

HEALTH STATUS LOCAL HEALTH CARE ENVIRONMENT

There are many social, economic and environmental factors that contribute to the population's overall good health, including an exceptional drinking water supply, high quality housing, an excellent regional economy with low unemployment, and top-ranked public schools. Environmental laws and regulations are tightly enforced and Nassau was largely spared the long-term environmental insults from heavy industry and manufacturing. There are many parks, beaches and recreation areas maintained by the state and county. The quality of medical care is good and in some disciplines local hospitals are among the best in the state. Nassau county residents are well educated (almost 87% have high school diplomas and 35% have bachelor's degrees or higher) and the median and average household income are among the highest in the nation for any county.

However, there are other features of the social and environmental landscape that contribute to health problems. Many of the racial, ethnic and geographic health disparities described in earlier sections are in part due to environmental disparities, such as differences in economic and educational opportunity, poor housing, exposure to hazardous materials or working conditions, less access to health care (including mental health and substance abuse treatment), institutional racism and ethnic discrimination.

Racial Residential Segregation and Health

Historic housing practices, ranging from post WWII mandated mortgage restrictions to racial steering, have left Nassau County highly segregated. One report found that although *"economically segregated housing is prevalent on Long Island, African Americans, in particular, are victims of racial steering."*¹⁷ U.S. Census data shows two thirds of Long Island's cities, towns and villages remain largely white with less than 1% black residency. Ninety percent of Long Island's black residents live in just 20% of its communities (e.g. Roosevelt, Hempstead Village).

Racial residential segregation indices of the U.S. Census measures the isolation of a population from other populations by considering racial/ethnic clustering (regardless of income) and the concentration of a racial/ethnic population compared to other populations. Some have found a correlation between segregation and mortality, birth outcomes and tuberculosis.

Housing and Other Physical Threats and Health

Poor quality housing conditions (exposure to lead paint, mold, overcrowding, etc.) have been associated with infectious disease, injury, lead poisoning and asthma in children. Three quarters of the County's houses are more than 40 years old. Where repairs and remediation of problems fail to take place, there is potential for health problems. At issue too in areas of Nassau County, and across the nation, is the number of new immigrants living in overcrowded conditions that have the potential to further exacerbate many health issues.

Homelessness is a very real threat to health. The Nassau Suffolk Coalition for the homeless estimates that there are 40,000 homeless persons in the combined counties of Nassau and Suffolk and another 200,000 at risk of becoming homeless.

Gang violence is a source of physical health threats in some communities in Nassau. Homicide and assault rates are higher among ethnic and racial minorities, and in the select communities

Environment and Health

Nassau County ranks high in environmental protection by conducting ongoing enforcement of environmental laws, regulations and ordinances and by investigating and resolving environmental emergencies. (A full description of the role of the LHD Environmental Health Division can be found in *Section II – Local Health System Profile*.)

However, a disproportionate number of EPA superfund sites and brownfields are in communities of color. Although exposure to toxic chemicals from these sites is rare and unlikely (due to remediation and treatment of drinking water), their presence stunts economic development and often is seen as a blight on the community.

Education and Health

Although Nassau has some of the top public schools in the nation, two of the most troubled districts in the state serve Roosevelt and Hempstead Village. Although it is hard to qualify the health impact of poor education, it almost certainly lessens economic opportunity, depresses property values and discourages new business ventures.

Cultural Competence of the Health Care Workforce

A culturally competent workforce is an important part of providing excellent medical care. According to the National Center for Cultural Competence:¹⁸

1) Diverse cultures perceive illness and disease and their causes differently; 2) There are differences in the belief systems relating to health and healing; 3) Behavior related to getting health care and attitudes toward health care providers is cultural; 4) Personal experiences affect a patient's attitudes toward health care systems and providers; and 5) There is an under-representation of providers from diverse cultural and linguistic backgrounds in the existing health care system.

September, 2004, the Sullivan Commission on Diversity in the Health Workforce found that while blacks, Native Americans and Hispanics make up more than 25% of the U.S. population, they represent only 9% of the nation's nurses, 6% of doctors and 5% of dentists. It can be assumed that the percentages are about the same or less in Nassau County. While it may not be necessary to have the workforce mirror the population demographically, it is important that providers be proficient in relating to the cultures (racial, linguistic) within their practices. Most organizations within the Nassau County Public Health System have provided their staff with cultural competency training and seek to ensure that the lessons are implemented.

Section II – LOCAL HEALTH SYSTEM CAPACITY PROFILE

Essential Public Health Services

In 1994 the CDC and other public health organizations described ten essential public health services that should be obtainable in every community in the United States. They are:

- Monitor health status to identify community health problems.
- Diagnose and investigate health problems and health hazards in the community.
- Inform, educate and empower people about health issues.
- Mobilize community partnerships to identify and solve health problems.
- Develop policies and plans that support individual and community health efforts.
- Enforce laws and regulations that protect health and ensure safety.
- Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
- Assure a competent public health and personal health care workforce.
- Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
- Research for new insights and innovative solutions to health problems.

The National Public Health Performance Standards Program (NPHPSP)

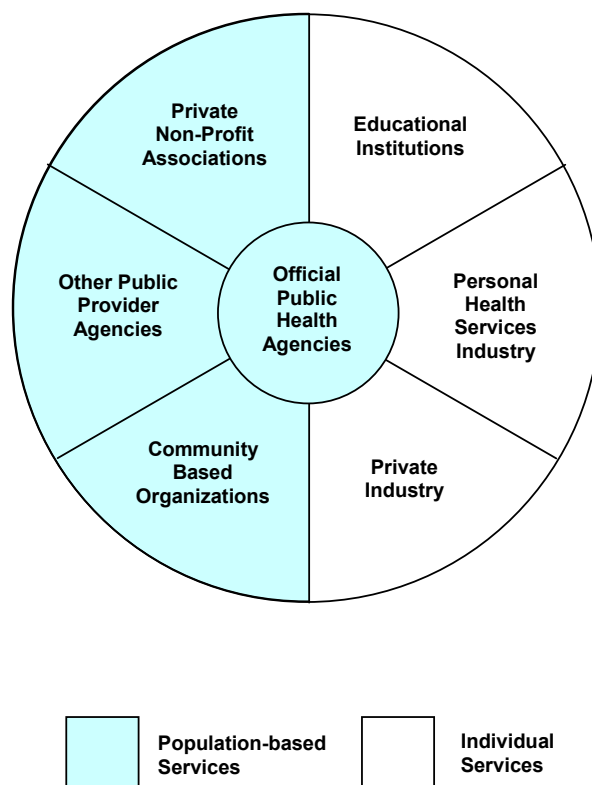
The Essential Public Health Services became the basis for development of the National Public Health Performance Standards Program (NPHPSP). The purpose of the NPHPSP is to assess the capacity and performance of every community's public health system. This includes the "use of the public health system as the unit of analysis for performance and capacity assessment"¹⁹. A public health system consists of the Federal, State and local health department and laboratories and also includes all those organizations that contribute to the delivery of essential public health services (Figure 26).

In 2001, using the NPHPSP Local Public Health System Performance Assessment Instrument, the Nassau County Department of Health and its partners performed an assessment of the Nassau County Health System (see Appendix: Exhibit 6 LPHS 8). The System performs best in the traditional public health activities of enforcing laws and regulations; diagnosing and investigating health

problems; researching for new insights and innovative solutions; monitoring health status; and informing, educating and empowering people. However, the system was weakest evaluating effectiveness, accessibility and quality; mobilizing community partnerships; developing policies and plans; linking people to needed services and assuring a competent workforce.

Figure 26

COMPONENTS OF THE LOCAL PUBLIC HEALTH SYSTEM



Local Health Department Overview

The Nassau County Department of Health was established in 1938 pursuant to Article IX of the County Government Law, and operates under the New York State Public Health Law and Titles 10 and 6 of the Official Compilation of Codes, Rules and Regulations of the State of New York.

The Vision - The Nassau County Department of Health will lead a public health system that works to create healthy communities.

The Mission - The Nassau County Department of Health promotes and protects the health of the residents of Nassau County. The mission is accomplished through direct services and community partnerships in the following focus areas:

- Prevention of environmental health hazards through assessment, regulation and remediation.
- Investigation and control of communicable diseases, including agents of bioterrorism.
- Promotion of healthy behaviors through education, outreach and training.
- Promotion of equal access to culturally and linguistically appropriate health care and allied services.
- Development and dissemination of local health data.
- Creation of innovative solutions to public health problems

Local Health Department Divisions:

Administration - Overall leadership and direction of the LHD are provided by the Administration unit. Also in this category are the administrative support functions of fiscal, human resources, Article 6 reporting, community health assessment planning, information technology and public information.

Environmental Health - The Division of Environmental Health protects the community from environmental pollution, unsanitary conditions or unsafe environmental practices. It monitors safe drinking water, food, and indoor and ambient air quality. It investigates complaints, conducts tobacco compliance checks, responds to emergency spills and incidents, controls and regulates the storage, handling and disposal of hazardous material and toxic chemicals and monitors the abatement of household lead hazards. It inspects radiological health diagnostic equipment, food service establishments, and provides training to food handlers and participates in food-borne outbreak investigations. It oversees recreational facilities including children's camps, pools and bathing beaches, certifies lifeguards and tattoo artists, conducts mosquito control surveillance and coordinates the County's Pesticide Policy.

Disease Control - The Division of Disease Control protects the public from the spread of communicable or infectious diseases by investigating reports of these diseases, surveillance for diseases and taking actions to prevent potential outbreaks. Some of the actions taken to prevent outbreaks include: immune globulin prophylaxis for those exposed to hepatitis A, immunizations for those exposed to measles, and confirmation of treatment for those infected with tuberculosis (TB). The Division maintains a 24-hour medical consultation service for notifiable diseases.

Division of HIV and STD Control - Activities of this division focus on risk reduction, education, and early identification of those infected with HIV, gonorrhea,

syphilis and chlamydia. These activities are done in partnership with health care providers, community-based organizations, the faith community, schools and other county agencies. The division collects HIV/AIDS and STD statistics and assists newly infected individuals in notifying their sexual and needle-sharing contacts through its Partner Notification Assistance Program (PNAP).

In addition, the LHD contracts the Nassau University Medical Center to provide clinical preventative services and treatment for STDs and TB at its community health centers.

Community & Maternal Child Health Services - The Division of Community & Maternal Child Health Services provides support to community-based programs and facilitates coordination and integration of services to children and families. It includes:

- Community Health Worker Program
- Office of Children with Special Health Care Needs
 - ♦ Early Intervention Program
 - ♦ Pre School Program
 - ♦ Physically Handicapped Children's Program
- Office of Emergency Medical Services and Bioterrorism Preparedness
- Perinatal Services Network
- Women, Infants & Children Program (WIC) Program

Public Health Laboratories - The Division of Public Health Laboratories provides essential analytic and diagnostic laboratory services to assess the status of community health in Nassau County and maintains the necessary technical expertise and instrumentation to evaluate disease outbreaks, monitor disease control programs, and test for the presence of bacterial and chemical contaminants in the environment. Six specialized clinical and environmental laboratory units provide:

- Serodiagnostic screening and confirmatory testing for communicable diseases
- Immune status evaluation for communicable diseases
- Comprehensive cultural and microscopic capabilities for identifying the pathogenic agents of communicable diseases
- Capabilities for tracking foodborne illnesses
- Identification of disease carrying insects
- Capabilities for the identification of bacterial and chemical agents in water, air, soil, dust, and consumer products
- Environmental screening for critical agents of bioterrorism (i.e. - anthrax)
- Spectrometric "fingerprinting" of unknown chemical agents to address chemical spills or other environmental emergencies involving toxic and hazardous materials

Section III – PROBLEMS AND ISSUES IN THE COMMUNITY

A Discussion of the Unmet Health Needs of the Residents of Nassau County

As a whole, Nassau County's residents receive quality health care, live in adequate housing, have essential social supports and are protected from most environmental hazards. Sometimes hidden in the overall data, however, are the increasing numbers of those who suffer disparities in health care.

Health Status – Disparities

As pointed out in the Executive Summary, disparities and inequalities are most prevalent in underserved communities and among racial and ethnic minorities. The most evident of these health disparities are in infant mortality, HIV/AIDS, STD's, chronic disease, teen pregnancy and violence. The root of the causes are socio-economic factors which are numerous and complex, and include differences in income, education, exposure to hazardous materials or working conditions, housing conditions, access to health care (including mental health and substance abuse treatment), as well as discrimination founded in institutional racism and ethnic differences. Reducing or eliminating disparities is one of the most important goals for the Nassau County public health system and should be addressed at all levels.

Health Care Safety Net – Access to Care

It is estimated that 14-20% of the County's residents are uninsured or underinsured. The estimate includes those persons not legally eligible for public health insurance programs, working adults who do not qualify for public assistance but yet do not receive insurance through their employers, and persons who choose not to be insured (many young adults, students and some elderly). Many residents rely on subsidized or charity care provided by local hospitals and occasional "pro bono" primary care provider sites. Historically, the Nassau County government (through the Nassau County Medical Center and the Health Department clinics) provided free or subsidized care to residents in need. In 1999, the Nassau Health Care Corporation took over these operations. NHCC (Nassau University Medical Center with hospital outpatient clinics, seven community health centers, and a nursing home) provides a full range of services, including general medicine (adult and pediatric primary and preventive care), maternity, gynecology, family planning, HIV, TB, STD, mammography, immunizations and dental. Services at the Health Centers are provided on a sliding fee scale based on family size and income. The locations and hours of operation are listed in Appendix: Exhibit 6LPHS3.

Other "safety net" providers include Winthrop University Hospital's school-based health center at Hempstead High School and two charitable clinics (Rotacare and the Community Wellness Center). Nassau hospitals such as Long Beach, South Nassau Communities Hospital and the North Shore University Long Island Jewish Health System operate clinics with sliding fee scales. These institutions provide charitable, uncompensated care, but some are located outside of the selected communities and may at times be difficult to access by those in need.

An even larger problem exists in accessing medical specialty services and diagnostic evaluations, arranging surgical procedures and obtaining medications. These types of services typically require payment on the part of uninsured patients, for at least a portion of the total charges. Although many facilities offer discounts to the uninsured for services, the high cost of medications, diagnostic procedures and specialist services creates barriers for the uninsured resulting in delayed care or no care at all.

The Public Health System – Gaps

In 2002, under the auspices of the CDC, the LHD undertook an evaluation of the local public health system and its ability to provide the ten essential public health services. This qualitative assessment was based on input by health care providers, advocates, community organizations and LHD personnel. Four of the ten essential public health services were identified as being in definite need of improvement. The summary scores, 0 % (least effective) to 100% (most effective), were:

- Evaluate effectiveness, accessibility and quality of personal and population-based health services - 25%.
- Mobilize community partnerships to identify and solve health problems - 29%.
- Develop policies and plans that support individual and community health efforts - 42%.
- Link people to needed personal health services and assuring provision of health care when otherwise unavailable - 44%.

Collaboration and partnership is particularly critical for the LHD. With loss of staff and services throughout Nassau's public health system, it is necessary to develop, sustain and/or increase partnerships with public and private agencies, health care providers and community and faith based

organizations. Most of the unmet needs in the health care delivery system can be viewed as a malfunction in leveraging non-governmental resources in the face of diminishing LHD capabilities.

For a discussion of services provided by the Local Health Department and its partners, refer to Section II of this report. For a listing of community partners and their missions see Appendix: Exhibit 6LPHS7.

Section IV – LOCAL PUBLIC HEALTH PRIORITIES

The local public health priorities listed below reflect organizational and community needs and the input of the LHD's partner agencies (see Appendix: Exhibit 6LPHS7 for a list of organizations).

- Reducing health disparities
- Reducing the burden of chronic diseases through community prevention programs
- Improving bioterrorism and emergency response capabilities
- Strengthening public health infrastructure
- Improving the health care safety net (focus on cultural competency)

Reducing health disparities - The LHD has developed partnerships with community-based organizations, health care providers and other County agencies to reduce health and health care disparities by improving access to and the quality of health care services for all County residents. This effort was aided by the Minority Health Task Force (MHTF) report that made eight specific recommendations to make health care more equitable and accessible to all residents, especially the poor and uninsured.

One of the ways the LHD focuses attention on health disparities is by issuing reports, such as the Community Health Assessment. Attention is called to seven communities in the County that are most in need and also have the largest numbers of minority (racial and ethnic) populations. These "selected" communities have disproportionately higher rates for many diseases and more adverse social and economic conditions.

Many LHD programs are specifically designed to reduce disparities. The Community Health Worker Program (CHWP), located in the Village of Hempstead, provides outreach, education, and home-based case management services to at-risk pregnant woman and their families. CHWP works in collaboration with community, health care providers, the Economic Opportunity Commission's Healthy Start Program and the Nassau County Perinatal Services Network. The Perinatal Services Network (PSN) provides residents and providers with information and resources to help improve birth outcomes and access to prenatal-perinatal health care services. This is accomplished through a consortium of more than 30 health and human services providers that work together to identify gaps in services and recommend systematic changes to improve prenatal care.

The Women, Infant and Children's Nutrition Program (WIC) provides nutritional counseling and food vouchers

to more than 12,000 low-income participants. WIC also provides training in parenting skills (i.e. – to reduce child abuse) and runs a breast-feeding education initiative for minority women.

The STD Control Bureau works with Planned Parenthood to address the increase in syphilis among Latino men in the Village of Hempstead through outreach and education. The HIV Bureau continues to partner with the Black Leadership Commission on AIDS to address the ongoing HIV epidemic in African-American communities.

The MHTF will oversee two grant programs to support community efforts in this area. The first will fund community-based and faith-based organizations that organize monthly health forums that promote healthy behaviors or assist persons in managing chronic diseases (i.e., diabetes, heart disease). The second grant will support programs designed to reduce health disparities related to HIV infection, cancer and obesity.

The LHD's annual budget includes \$5 million for the Nassau Health Care Corporation to provide essential public health services to residents at six health centers located in communities with large minority populations. In 2005, over 65,000 patient visits were made.

Reducing the burden of chronic diseases through the community prevention programs - The LHD has been focusing on helping residents to improve their personal health behaviors. The Bureau of Health Promotion and Disease Prevention identifies needs and develops programs that promote healthy living and prevent disease, the most cost-effective ways to stay healthy. With increased health care costs and an aging population, all residents benefit from the Bureau's prevention activities. By working with local hospitals, health care providers, schools, community, nonprofit and faith based organizations, the LHD can leverage resources and develop initiatives and programs that target underserved and health disparate communities.

Smoking is the single greatest cause of preventable death and illness in Nassau. The LHD is continuing to expand its efforts to prevent or reduce tobacco use. Residents are offered a comprehensive, no-cost tobacco cessation program that supports and empowers participants to become tobacco-free. Now, residents can also receive free stop-smoking medication. The "Quitting for Your Family" program trains health care providers to identify pregnant women and new parents who smoke and helps them to quit. The LHD participates in the Tobacco Action Coalition of Long Island (TACLI) which promotes anti-tobacco youth advocacy and sponsors counter-marketing programs.

Childhood asthma is a leading cause of morbidity in the county and disproportionately affects minority communities. The LHD initiated a new program to reduce the frequency and severity of asthma episodes in low-income children through home visits and case management. Working with the Asthma Coalition of Long Island, the visits educate families about asthma triggers and provide them with the knowledge, skills, motivation, and supplies necessary to help protect their children from allergens.

While unhealthy behaviors play a major role in premature morbidity and mortality, local data necessary to effectively target resources has not been available. The LHD responded by conducting the County's first-ever comprehensive community health survey, which will provide important information about the risk factors and health problems affecting our communities. The results will be used to help improve public health programs through the development of strategic plans and targeted prevention programs, identification of trends in unhealthy behaviors over time and by supporting community policies that promote health and prevent disease.

Improving bioterrorism and emergency response capabilities - Through planning, drills, exercises and training, the LHD has greatly strengthened the public health system's ability to respond to bioterrorism and other public health emergencies, such as a potential influenza epidemic. The Public Health Emergency Response Plan (part of the County's all hazards plan) allows for coordination with the Nassau County Office of Emergency Management, Nassau County Police, HAZMAT and other emergency response agencies. It provides for lines of communication with Federal, State and local governmental agencies, hospitals, water districts and other organizations. Several Point of Distribution (POD) exercises and drills, done in cooperation with other agencies and local hospitals, have tested various parts of the emergency response. Future exercises will test continuity of operations among first responders, decontamination capabilities and surge capacity mobilization.

Monitoring and surveillance activities of communicable diseases are in place to allow for better identification of a bioterrorism event. Local hospitals have been involved in the planning and have "drilled" on response to biological and chemical agents. Four Nassau County hospitals are participating in the NYSDOH pilot syndromic surveillance system, which helps to identify unusual clusters of disease.

Awareness has been raised about the potential for a bioterrorist event in the health care provider community and the participation of this community has been solicited to assist in emergency planning. The LHD has formed a Medical Reserve Corps made up of licensed health care professionals who have volunteered to provide services during emergencies.

The LHD is the lead agency for naturally occurring and man-made disease outbreaks. and is part of the Cities Readiness Initiative, whose intent is to reduce the time it takes to provide prophylactic medication to the population after an outbreak through a network of other agencies, employers and municipalities. The Communicable Disease Control division has trained staff to provide post exposure testing and treatment for outbreaks

Strengthening public health infrastructure - Monitoring health status to identify community health problems and then informing people (the public, other government agencies, health care professionals and other organizations) about health issues are two core public health services. There is also an ongoing need to make better use of internal data to monitor and improve program activities.

Enhancements have been made to the LHD's website, making it easier to find information important to the public. The data section has been updated to include the 2005-2010 CHA along with other LHD reports and links to many useful websites. The website also contains descriptions and contact information for the many programs operated by our LHD. Improvements are ongoing.

An Office of Epidemiology has been created within the LHD. Its role is to improve the LHD's data collection and management capabilities to be able to provide useful information. The Office will be working with the NYSDOH to obtain data to be used for program assessment and analysis. The Office will be responsible for the development and dissemination of reports to other agencies and the public.

The use of the Geographic Information System (GIS) is being expanded in the LHD. Examples of how this technology has been used in the past include mapping of the rabies raccoon and Early Intervention cases. We will be converting more databases onto the County's GIS system.

Improving the health care safety net (focus on cultural competency) - In partnership with the MHTF, the Nassau Partnership for Healthy Communities, and CBOs, the LHD is promoting cultural competency training, particularly for safety net providers. Planned Parenthood and Winthrop Hospital are among the organizations that have already performed self assessments and/or have obtained specific training to become more culturally competent in their understanding of culture in the workplace and heighten their performance and productivity.

The MHTF recommended that all staff in Health and Human Services agencies receive cultural competency training. The LHD has provided training to Executive staff and supervisors and has integrated it into its new employee orientation materials.

Section V – OPPORTUNITIES FOR ACTION

Introduction: Nassau's overall health compares favorably to other large counties, but the health of those in communities with large numbers of poor and minorities is far worse than that of the County as a whole. Among the reasons, cited previously in this report, are poverty, insufficient access to health care, unhealthy behaviors, inadequate housing and low educational attainment (see Appendix: Exhibit 1DEM8).

Nassau has a long-standing commitment to public health. The county was one of the first suburban counties in the United States to establish a public hospital (Meadowbrook Hospital), followed by the creation of the A. Holly Patterson county nursing home (1952) and later a network of community health clinics under the Health Department (LHD). Over the past twenty years, Nassau has been a leader among suburban counties in confronting environmental hazards (ground water protection, marine environments), communicable diseases (AIDS, West Nile Virus), infant mortality (Infant Mortality Prevention Program, Perinatal Services Network), early childhood development (Early Intervention Program) and access to health care (Nassau County Charity Care Law).

The LHD, as the leader of the local public health system, is responsible for setting public health priorities and identifying *Opportunities for Action* -- policies, programs, and community initiatives that have the greatest chance of making a real and lasting difference to the County's health. These are referenced below by type of intervention (policy, program, county financial support/subsidy) or the part or parts of the public health system (local or state government, health providers, community-based organizations, etc.) most capable of taking the action.

Health and Health Care Disparities

Reducing or eliminating health disparities is a top priority for County Executive Suozzi's administration.

Maximize Enrollment in Health and Social Service Programs (County Health and Human Service agencies, managed care organizations, community-based organizations (CBOs), health providers). New York State has public health insurance programs (Medicaid, Child Health Plus, Family Health Plus, and subsidized insurance plans for small businesses), but many Nassau residents do not apply or enroll. A better understanding of barriers to participation, and closer coordination between County agencies, facilitated enrollers, health care providers and CBOs could increase enrollment in these programs, as well as WIC, food stamps and other entitlement services.

Strengthen the Health Care Safety Net (Local and state financing, local and state health, health care providers, coalitions). In Nassau, a combination of clinics, hospitals, and private practices provide care to Nassau's in need communities. The Nassau Health Care Corporation (NHCC) is the largest safety net provider and receives almost \$20 million to support this effort. Through its anticipated reorganization and affiliation with the North Shore-Long Island Jewish Health System, there will be substantial opportunities to strengthen and expand the community health centers, improve prison health services, provide subsidized medications to ambulatory patients, and improve the hospital's standing in the community. Subsidies to the NHCC should be contingent on meeting these basis community needs.

Provide Better Health Information on Community and Subpopulation Levels (Local and state agencies, local research universities and/or foundations). The use of better computer technology for analysis of electronic health information and new web presentations provide opportunities for the LHD to further its mission of distributing public health information in a timely and efficient manner. In particular, the provision of data on the health of small communities and health behaviors could enhance public health and health care planning in the region. To this end, the LHD is completing its first Behavioral Risk Factor Surveillance Survey (BRFSS) and is participating in the publication of the Long Island Social Health Index. However, the County still needs to conduct a Youth Risk Behavior Survey (YRBS) to complement these two studies.

Expand HIV Prevention Programs (County and state support; state policy; health agencies and CBOs). AIDS continues to disproportionately affect African Americans. Although rates of AIDS and AIDS mortality have fallen due to better treatment, the proportion of cases among African Americans and Hispanics has increased. Underused prevention opportunities include providing condoms in schools, establishing needle exchange programs, expanding HIV testing sites and supporting "Prevention for Positives" case management programs.

Demographic Shifts

Nassau is undergoing a rapid demographic shift reflected by growing racial and ethnic minority communities, and a rising proportion of persons over age 65. These changes will put new demands upon the medical, social services and education systems in the County.

Promote Culturally Competent Health Care (Health care providers, local and state health agencies). The MHTF also strongly recommended that all health care providers conduct internal assessments and develop systems and training to make their institutions and employees cognizant and sensitive to the cultural beliefs and practices of their patients. The LHD endorses that recommendation, and has supported these activities through the Nassau Partnership for Healthy Communities.

Create Point of Entry System for Long Term Care in Nassau County (NYS Office of the Aging and NYS Department of Health). The development of a *Point of Entry System for Long Term Care* will seek proposals from counties for offering information, assistance and screening for all long term care services. Phase Two *Point of Entry* will provide a comprehensive needs assessment, authorization for publicly-funded long term care services and case management assistance.

Unhealthy Behaviors

Certain behaviors put individuals and communities at risk for poor health and increased rates of disease and premature death from chronic disease. Changing dangerous and unhealthy behaviors is difficult and requires the sustained commitment of many different groups and agencies, with success measured over the course of years or even decades.

Build on successes in tobacco control (Local and state financial support, state policies, local programs). Despite recent reductions in the prevalence of smoking, tobacco is still the foremost cause of preventable deaths and illness in Nassau County. Approximately 18% of adults in Nassau County smoke (2003 NYS Expanded BRFSS). The LHD endorses various measures to further reduce smoking, and prevent initiation, including increasing the tax on tobacco products, continuing enforcement of the Adolescent Tobacco Use Prevention Act. (ATUPA) restricting tobacco sales to minors and funding counter-marketing campaigns. A portion of the States Attorney Generals' settlement award should be dedicated to tobacco control efforts.

Encourage Exercise and Healthy Diets (Programs and environmental intervention; schools, local and state health, local planning agencies). The percentage of Nassau County adults who are overweight or obese is now over 50%. More alarming, a growing percentage of school-age children in New York State are overweight (20%). Stopping and reversing this trend will require a change in policies, programs and environmental interventions, although few of them have proven effective. One of the few promising interventions is

providing more exercise and healthier food in the schools. The LHD will be encouraging school districts to adopt healthy dietary practices, limit the sale of sodas and candy in vending machines, and increase the time devoted to vigorous exercise during the school day. Promoting physical activity beyond school years is a multi-billion dollar industry. Potential local public health interventions include promoting non-vehicular commuting (bike and walk to public transportation, and worksite physical activity programs).

Reduce High Risk Sexual Behavior (Local programs, local and state financial support). Some of the most striking health disparities (rates of HIV infection, hepatitis B, syphilis and teen pregnancy) are tied to high-risk sexual behavior, including unprotected intercourse. While rates of most sexually transmitted diseases and teen pregnancies have been declining for the past 20 years, rates in minority communities are still disproportionately high. Many different parts of the health care system, including health care providers, schools, religious institutions, and community based organizations will need to continue to provide accurate information and teach skills to teens and young adults. It is equally important to assure free or low cost family planning services (including emergency contraception) through Title X family planning programs.

Provide Substance Abuse Treatment and Services (Local programs, state policy). Drug and alcohol abuse and addiction cause substantial morbidity and social and economic burdens to society. Nassau needs to increase the number of inpatient detoxification and treatment facilities and promote the use of buprenorphine (an opiate agonist-antagonist) as an alternative to long-term methadone treatment.

Public Health Infrastructure

The threat of bioterrorism, newly emerging infectious diseases and a potential influenza pandemic have brought about new, unprecedented responsibilities for public health agencies which call for an assessment of core capacities and a recognition of the need for capacity building to contend with the growing importance of preventing or reducing chronic disease, especially those tied to unhealthy behaviors.

Establish or Expand Public Health Coalitions and Partnerships (Local government, professional organizations, health care providers, academia, CBOs). Because so many different organizations share at least some of a public health mission, coalitions and partnerships are effective mechanisms for focusing interest, leveraging resources, and implementing creative solutions.

The LHD should develop or continue partnerships focused on oral health, chronic disease control and prevention, health disparities and health care access. Coalitions are also important for attracting outside funding for local initiatives.

Improve Emergency Response Capabilities (State and local health agencies, emergency management, fire, police, EMS, health care providers). Since the late 1990's, there has been growing awareness of the threat posed by natural or man-made (bioterrorism) epidemics, and the role that public health would play in identifying the outbreak, mitigating its effect, and communicating about the threat. The LHD will continue to develop and modify its emergency response plans in conjunction with Nassau County OEM, train LHD and other HHS staff in disaster response and incident command, and test our capabilities through drills and exercises.

Make Public Health Data and Information More Available (State and local health agencies, academic institutions). An effective public health system depends on accurate and timely information on the population's health, including the appearance of new diseases, disease trends, program effectiveness and the prevalence of health determinants and behaviors. Even yearly updates are often out-of-date and do not adequately serve the needs of public health partners, political leaders or the community at large. The LHD should increase the resources directed at data collection, conducting epidemiological analysis and improving its communication capabilities, particularly using Web and geographic information systems (GIS) technology.

Environmental Health

Add Fluoride to Public Water Supplies (Local policies and programs; health department, oral health coalition). The Centers for Disease Control selected fluoridation of public water supplies as one of the most important public health initiatives of the 20th century, yet not one of the 54 water districts serving Nassau County currently adds fluoride. Even at a time where fluoride is available in tablets, toothpastes and in dental sealants, water fluoridation protects and improves children's oral health. The LHD, as part of the Nassau Oral Health Coalition, will engage politicians, health professionals, and community leaders to compel water districts to add fluoride in accordance with ADA recommendations.

Continue Proactive Measures to Protect Sole Source Aquifer (State and local policies; state and local programs; Department of Environmental Conservation, NYSDOH, LHD, water districts, environmentalists). Long Island has one of the great water supplies on the east coast. Policies and regulations need to provide for its continued purity. In addition to continuing its various programs to

prevent spills and clean up existing contaminants, the LHD will review and provide opinions on any policy or proposal that will impact on the aquifers.

Provide Public Health Input for Land Use, Planning and Transportation (Regional Planning Association, private developers, Metropolitan Transportation Association, towns and villages). The growth of Long Island depended on private automobiles, which in turn guided many of the planning decisions over the past 50 years. However, automobile traffic is the foremost cause of air pollution on Long Island, and development that favors the use of private cars also deters people from walking and exercising. County Executive Suozzi has advocated for the development of walkable communities, the reinvigoration of downtowns, and the expansion of public transportation. The LHD will champion efforts that increase physical activity (walk to school program) and promote safe walking and biking (the Long Island Non-Motorized Transportation Study).

Maternal and Child Health

Work Towards Lead Poisoning Elimination (State and local health, medical professionals, builders and renovators). Lead levels, and instances of lead poisoning (lead >20 mg/dl) have declined in Nassau County, and we are at the point that we can look towards eliminating lead poisoning. This will require continued surveillance for and investigation of low-level poisoning, oversight of abatement efforts, education of homeowners who are renovating old homes and vigilance for the sale of lead-containing products sold as medicines, cosmetics or children's toys.

Effectively Manage the Early Intervention (EI) and Pre-School Programs. The most expensive public health programs (excepting Medicaid and other health insurance programs) are EI and Pre-School. Every child suspected of having a developmental delay needs a prompt and accurate evaluation, and when eligible, receive effective treatment or services until the delay resolves or the child leaves the program. The LHD needs to work with school districts, service providers and parents to ensure that minority children are properly referred for evaluation and that services are provided in an equitable manner, without regard to community or school district.

Re-establish MCH public health nursing program. One of the great traditions in public health is nurses assisting new mothers in caring for their babies. Several recent studies have shown that home visiting (especially when done by trained nurses) is highly effective in increasing maternal skills, preventing child abuse, preventing unintended pregnancies and boosting the child's educational attainment. The LHD will pursue funding to reestablish a public health nursing program directed at assisting new, "high-risk" mothers.

References

¹ Wikipedia. <http://www.worldhistory.com>.

² U. S. Census Bureau. <http://www.census.gov/>.

³ *ibid.*

⁴ U.S. Census, American Community Survey 2003

⁵ U. S. Census Bureau. <http://www.census.gov/>

⁶ New York State Department of Labor.

⁷ Centers for Disease Control (CDC) National Immunization Program

⁸ NYSDOH, www.health.state.ny.us.

⁹ Trust for America's Health, "*F As in Fat: How Obesity Policies are Failing in America*"
<http://www.healthyamericans.org>

¹⁰ New York State Oral Health Surveillance System.

¹¹ Schools included in the survey were: Centennial Avenue School, Roosevelt NY, Franklin School, Hempstead, NY, Fulton School, Hempstead, NY, Harry D. Daniels, Roosevelt NY, Kennedy School, Great Neck, NY, Lido Elementary, Long Beach, NY, MG Rhodes School, Hempstead, NY, Stratford Road School, Plainview, NY, and Walnut Street School, Uniondale, NY

¹² New York State Department of Health Cancer Registry.

¹³ The Behavioral Risk Factor Surveillance System estimates are based on a survey conducted by telephone interview.

¹⁴ U.S. Department of Health and Human Services (HHS), www.hhs.gov/news/press/2004pres/20040309.html.

¹⁵ NYSDOH-BRFSS County Level Prevalence Estimates for 1994-1998, issued December 2000. (Female BMI \geq 27.3, Male BMI \geq 27.8)

¹⁶ IOM. Medicare: A Strategy for Quality Assurance. Vol.1. Lohr, K.N., ed. Washington, DC: National Academy Press, 1998

¹⁷ Erase Racism, www.eraseracismny.org

¹⁸ Georgetown University Center for Child and Health Development, <http://gucchd.georgetown.edu/nccc>

¹⁹ National Public Health Performance Standards Program (NPHPSP) Local Public Health System Performance Assessment Instrument (5B).

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Exhibit 1DEM 1

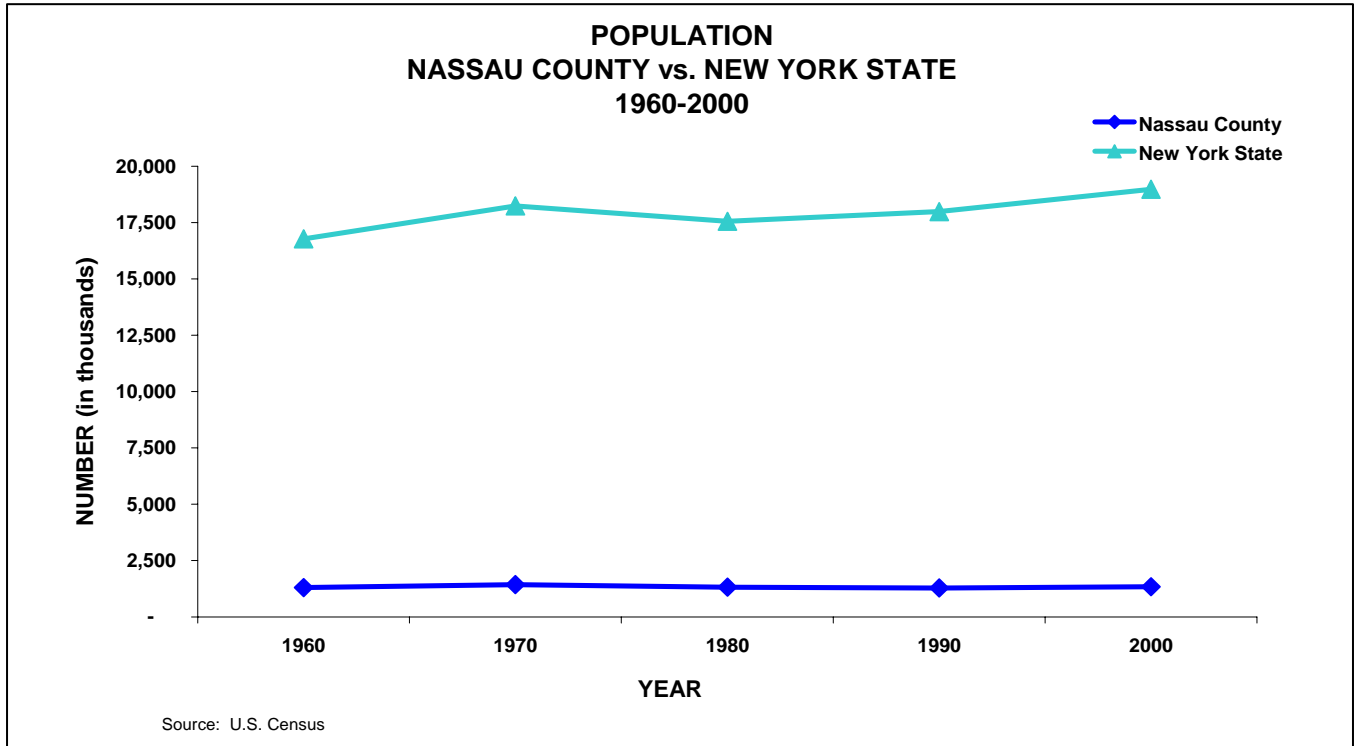


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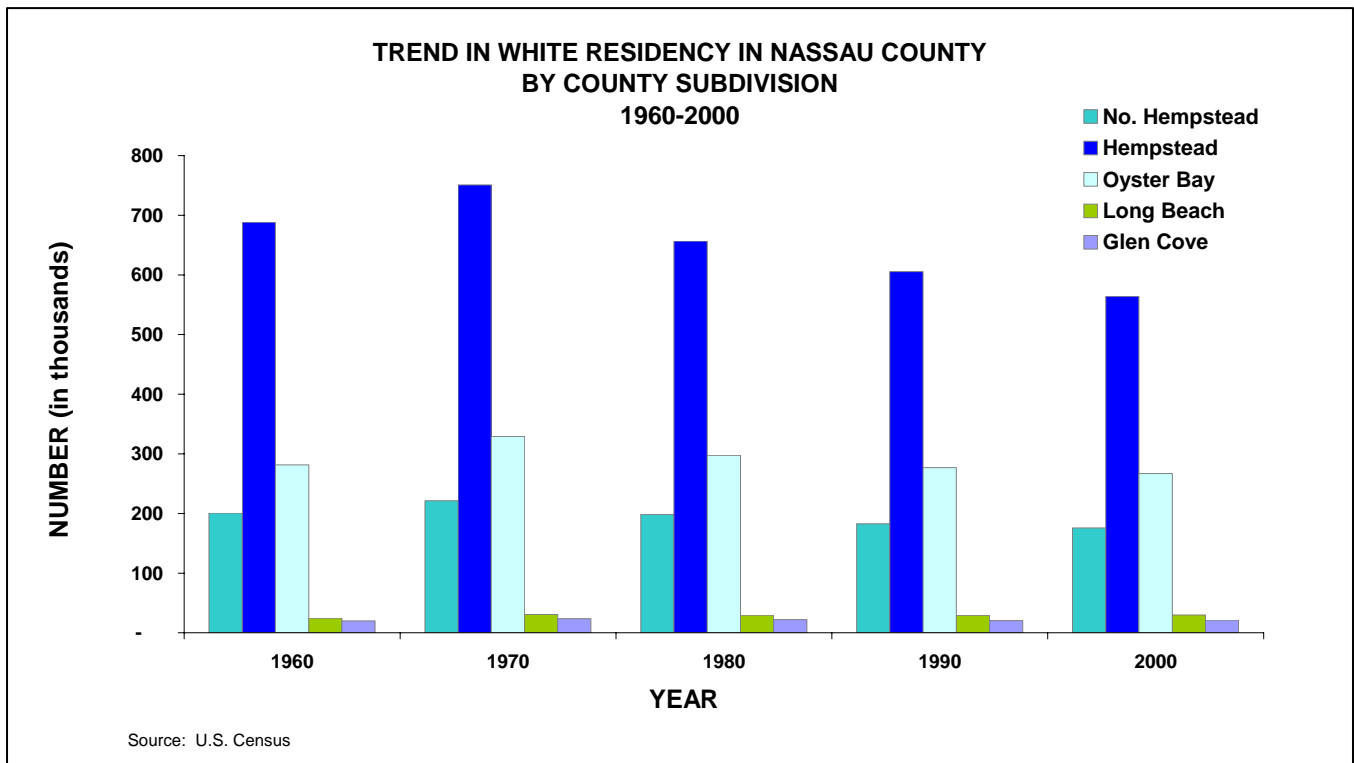


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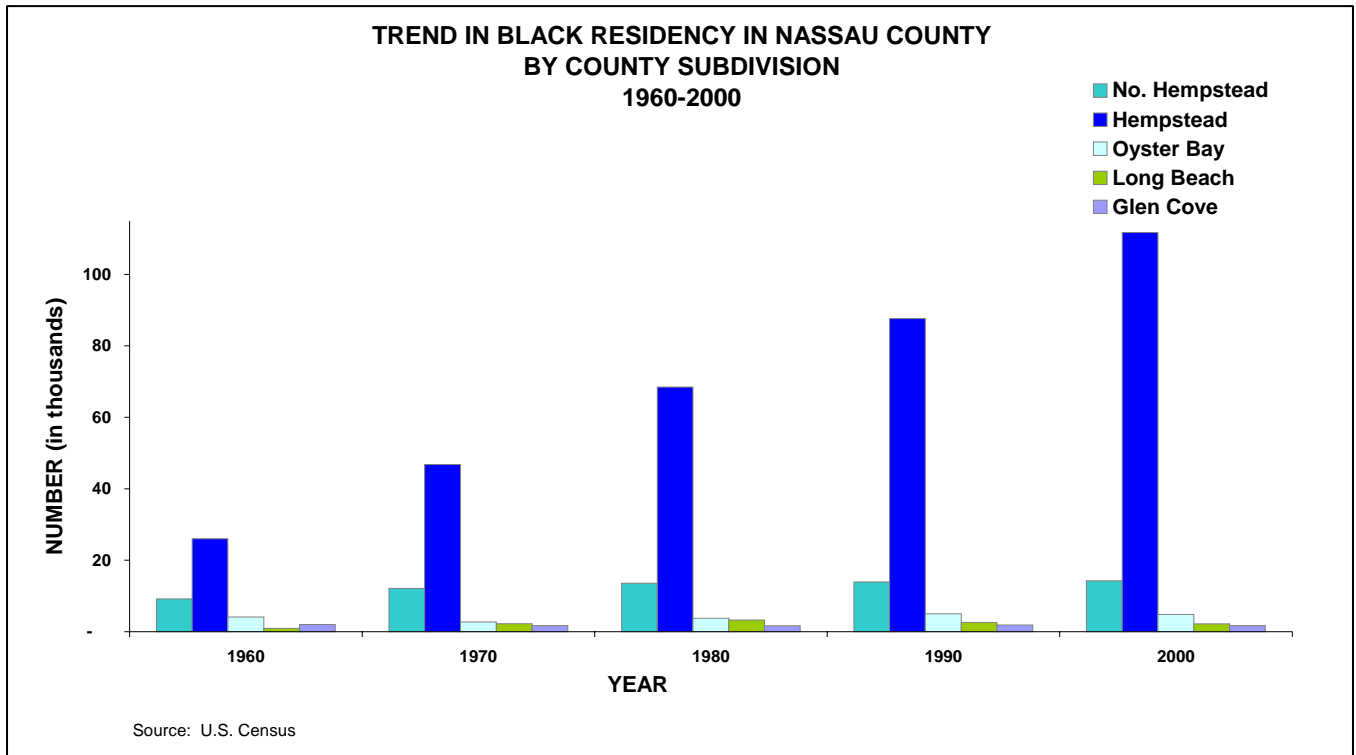


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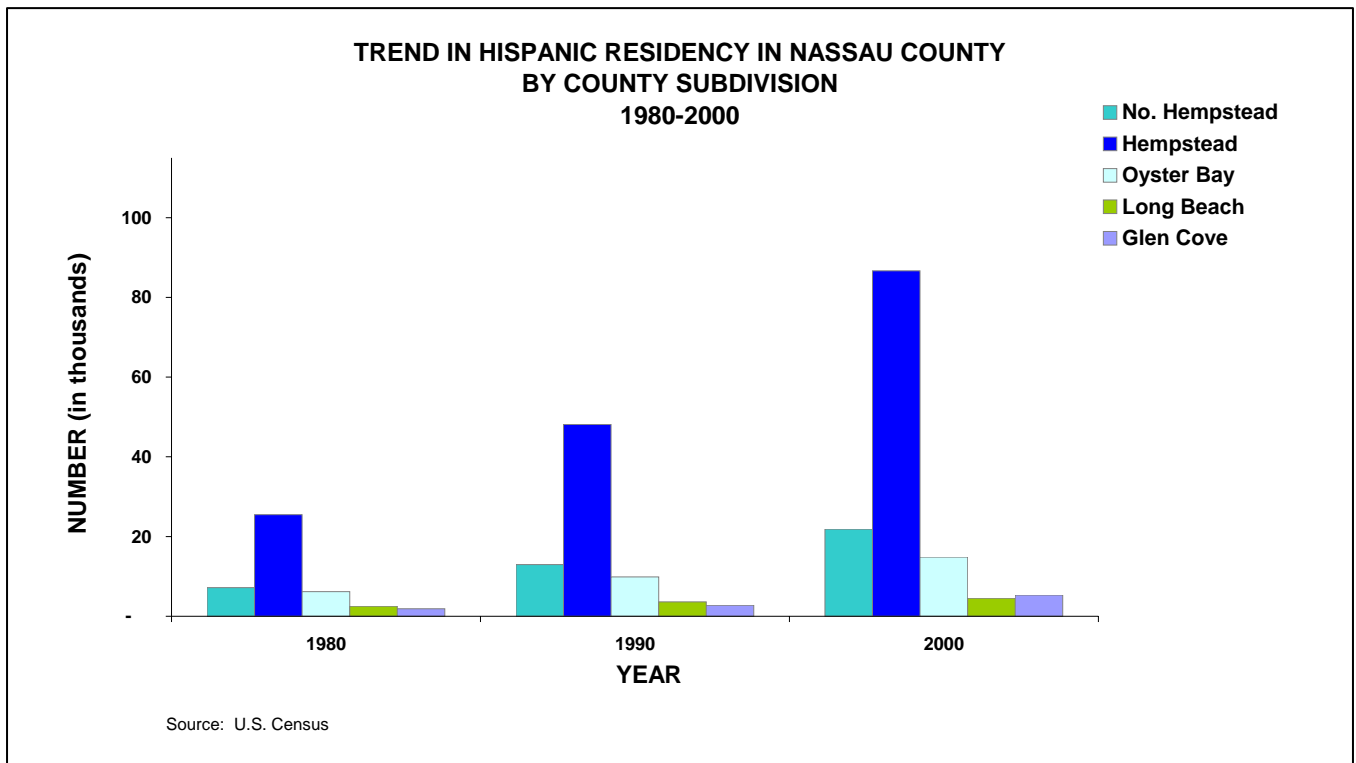


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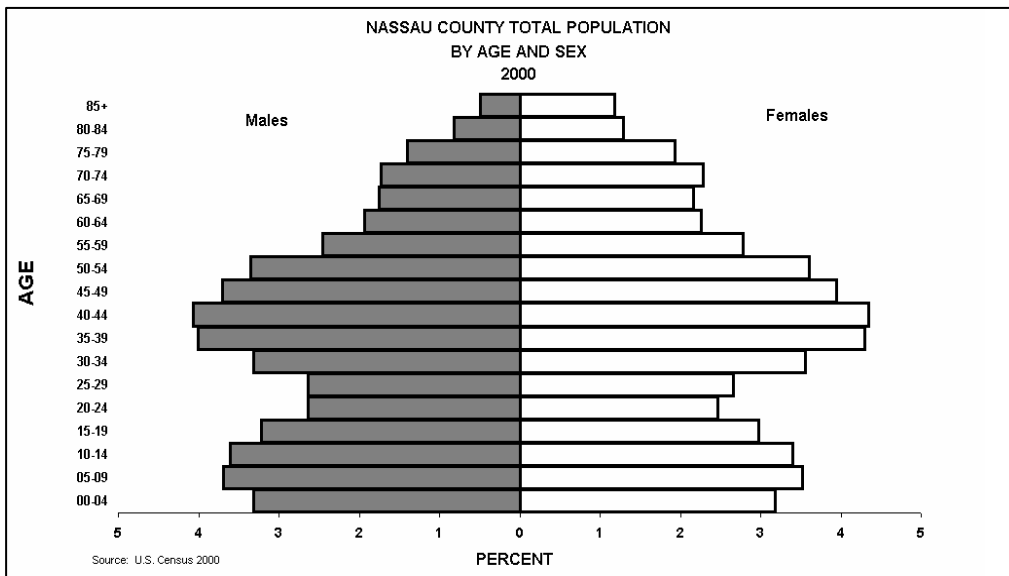


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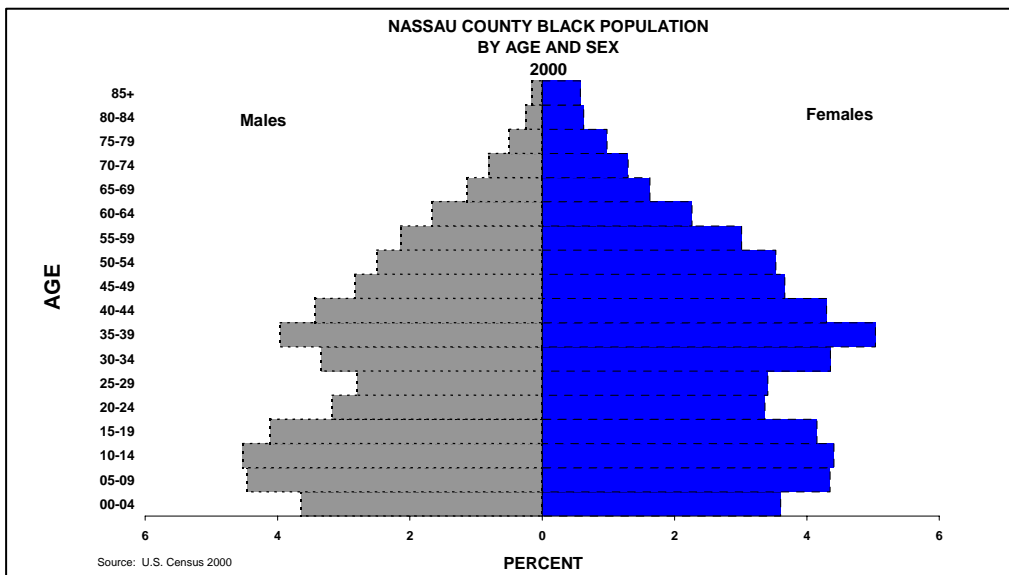


Exhibit 1DEM 7

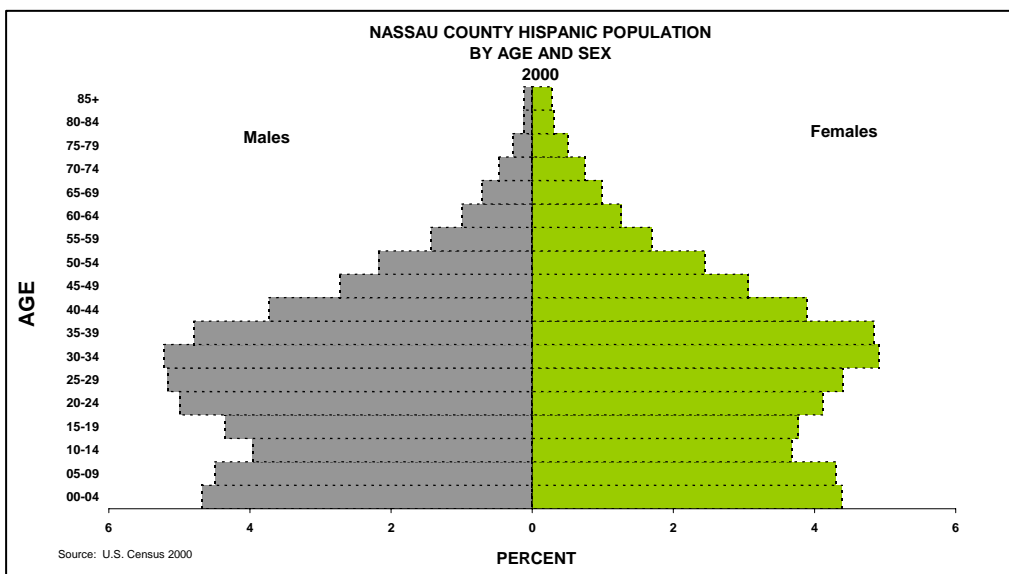


Exhibit 1DEM 8

COMMUNITIES IN NASSAU COUNTY
SELECTED BY DEMOGRAPHIC, HOUSING, ECONOMIC, SOCIAL AND HEALTH CHARACTERISTICS
(In rank order of the Community Needs Index¹)

DEMOGRAPHIC

ZIP CODE	REGION/ COMMUNITY	CNI ¹ (HIGH & MED ONLY)	NYS Perinatal Avg.Decile Rank ²	Population U.S. Census 2000	AGE	RACE				ETHNICITY
					Median Age	% White	% Black	% Asian	% Other	% Hispanic Origin
	United States			281,421,906	35.3	75.1	12.3	3.6	9.0	12.5
	New York State			18,976,457	36.0	67.9	15.9	5.5	10.7	15.1
	Nassau County			1,334,544	38.0	79.3	10.1	4.7	5.7	10.0
11575	Roosevelt	H	9.3	15,975	31.7	8.2	78.8	0.5	12.5	16.2
11550	Hempstead Village	H	8.8	59,022	29.6	27.8	50.9	1.3	20.0	31.0
11553	Uniondale	H	8.6	23,452	34.8	26.7	56.1	2.1	15.1	22.6
11096	Inwood	H	8.3	7,975	34.3	49.6	28.8	2.1	19.5	27.5
11520	Freeport	H	8.1	44,026	34.6	42.6	32.9	1.4	23.1	33.3
11050	Port Washington	H	NA	28,545	39.6	84.0	2.2	8.5	5.3	11.7
11590	Westbury	H	7.6	42,507	35.5	59.4	23.9	5.6	11.1	22.0
11561	Long Beach	M	6.4	39,582	40.0	85.5	5.6	2.2	6.7	11.8
11003	Elmont	M	7.0	40,507	35.9	45.6	35.4	8.5	10.5	13.3
11542	Glen Cove	M	NA	27,693	38.7	80.9	6.2	4.1	8.8	19.4
11570	Rockville Centre	M	NA	27,827	39.9	84.3	9.8	1.5	4.4	7.8
11554	East Meadow	M	NA	37,458	38.6	85.3	4.3	6.7	3.7	7.0
11552	West Hempstead	M	NA	23,309	37.3	71.5	18.0	4.4	6.1	9.2
11558	Island Park	M	NA	8,553	39.5	91.1	0.9	1.4	6.6	13.6
11001	Floral Park	M	NA	25,511	39.1	83.1	4.6	7.9	4.4	7.3

HOUSING

ZIP CODE	REGION/ COMMUNITY	CNI ¹ (HIGH & MED ONLY)	NYS Perinatal Avg.Decile Rank ²	HOUSING CHARACTERISTICS			
				Households	Families	Housing Units	Housing Unit Density (Per Sq. Mile)
	United States			105,539,122	72,261,780	105,480,101	
	New York State			7,060,595	4,673,485	7,056,860	
	Nassau County			447,387	347,172	458,151	1,598.0
11575	Roosevelt	H	9.3	4,104	3,362	4,234	2,343.5
11550	Hempstead Village	H	8.8	15,999	11,808	16,417	3,903.9
11553	Uniondale	H	8.6	6,146	4,933	6,321	2,271.4
11096	Inwood	H	8.3	2,594	1,912	2,676	1,905.8
11520	Freeport	H	8.1	13,504	9,911	13,819	2,770.5
11050	Port Washington	H	NA	10,450	7,799	10,708	1,083.6
11590	Westbury	H	7.6	12,438	9,899	12,660	2,016.6
11561	Long Beach	M	6.4	16,632	9,230	18,072	5,148.6
11003	Elmont	M	7.0	9,902	7,842	10,151	3,691.5
11542	Glen Cove	M	NA	9,826	6,944	10,105	1,446.1
11570	Rockville Centre	M	NA	10,114	7,248	10,357	2,887.0
11554	East Meadow	M	NA	12,185	9,648	12,374	1,972.9
11552	West Hempstead	M	NA	7,400	6,007	7,518	2,013.7
11558	Island Park	M	NA	3,011	2,262	3,094	1,387.0
11001	Floral Park	M	NA	8,888	6,736	9,098	3,371.1

Exhibit 1DEM 8 (cont'd)

ECONOMIC

ZIP CODE	REGION/ COMMUNITY	CNI ¹ (HIGH & MED ONLY)	NYS Perinatal Avg.Decile Rank ²	ECONOMIC CHARACTERISTICS						
				Household Median Income	Family Median Income	Per Capita Income	% Individuals Below Poverty	% Families Below Poverty	% Age 18 Below Poverty	% 65 & Older Below Poverty
	United States			\$ 41,994	\$ 50,046	\$ 21,587	12.4	9.2	16.1	9.9
	New York State			\$ 43,393	\$ 51,691	\$ 23,389	14.6	11.5	19.6	11.3
	Nassau County			\$ 72,030	\$ 81,246	\$ 32,151	5.2	3.5	5.8	5.6
11575	Roosevelt	H	9.3	\$ 57,252	\$ 56,528	\$ 17,349	14.5	10.4	14.3	13.5
11550	Hempstead Village	H	8.8	\$ 46,291	\$ 48,488	\$ 16,134	17.0	13.8	16.7	15.5
11553	Uniondale	H	8.6	\$ 61,232	\$ 67,264	\$ 19,069	8.9	6.1	7.7	12.6
11096	Inwood	H	8.3	\$ 41,569	\$ 47,325	\$ 16,087	15.2	13.9	17.5	13.9
11520	Freeport	H	8.1	\$ 55,943	\$ 61,658	\$ 21,201	10.8	8.1	11.4	7.6
11050	Port Washington	H	NA	\$ 85,086	\$ 102,064	\$ 47,448	5.5	4.0	5.5	4.6
11590	Westbury	H	7.6	\$ 71,147	\$ 74,520	\$ 24,151	7.7	4.7	6.8	6.9
11561	Long Beach	M	6.4	\$ 57,657	\$ 70,086	\$ 32,127	8.7	5.7	9.1	10.0
11003	Elmont	M	7.0	\$ 62,511	\$ 68,646	\$ 22,111	7.5	5.4	8.3	6.5
11542	Glen Cove	M	NA	\$ 56,635	\$ 64,237	\$ 26,818	8.8	5.9	9.8	9.1
11570	Rockville Centre	M	NA	\$ 79,679	\$ 102,184	\$ 40,039	5.2	3.0	5.8	5.7
11554	East Meadow	M	NA	\$ 67,185	\$ 74,691	\$ 27,076	3.8	2.3	3.3	4.2
11552	West Hempstead	M	NA	\$ 71,155	\$ 76,897	\$ 26,100	4.7	3.5	4.5	4.3
11558	Island Park	M	NA	\$ 65,214	\$ 71,568	\$ 26,655	8.1	5.4	7.4	10.3
11001	Floral Park	M	NA	\$ 71,295	\$ 82,667	\$ 29,419	1.7	2.9	1.6	6.7

SOCIAL

ZIP CODE	REGION/ COMMUNITY	CNI ¹ (HIGH & MED ONLY)	NYS Perinatal Avg.Decile Rank ²	SOCIAL CHARACTERISTICS					
				% Female Householder	% High School Graduate	% Bachelor's Degree or Higher	% Other Than English Spoken at Home	Public Assistance Recipients Rank ³	Medicaid Eligible Recipients Rank ⁴
	United States			36.1	80.4	24.4	17.9		
	New York State			42.1	79.1	27.4	28.0		
	Nassau County			35.0	86.7	35.4	23.2		
11575	Roosevelt	H	9.3	50.9	71.6	14.6	22.1	1	1
11550	Hempstead Village	H	8.8	52.0	67.6	16.5	36.6	2	2
11553	Uniondale	H	8.6	44.9	73.0	19.2	35.9	3	3
11096	Inwood	H	8.3	50.0	68.2	9.8	36.4	7	NA
11520	Freeport	H	8.1	42.4	72.9	20.6	36.8	4	4
11050	Port Washington	H	NA	36.1	90.5	53.2	30.5	NA	NA
11590	Westbury	H	7.6	35.5	76.9	28.0	38.7	5	5
11561	Long Beach	M	6.4	43.9	89.3	38.0	21.0	6	7
11003	Elmont	M	7.0	40.7	79.7	21.3	38.7	9	8
11542	Glen Cove	M	NA	38.9	77.8	27.9	38.1	8	9
11570	Rockville Centre	M	NA	38.9	90.7	49.4	14.5	NA	NA
11554	East Meadow	M	NA	33.3	86.5	29.0	21.3	NA	NA
11552	West Hempstead	M	NA	33.4	87.2	33.2	21.2	NA	NA
11558	Island Park	M	NA	40.3	83.3	19.5	24.5	NA	NA
11001	Floral Park	M	NA	35.3	88.8	34.6	21.2	NA	NA

Exhibit 1DEM 8 (cont'd)

HEALTH

ZIP CODE	REGION/ COMMUNITY	CNI ¹ (HIGH & MED ONLY)	NYS Perinatal Avg.Decile Rank ²	HEALTH CHARACTERISTICS						
				Infant Mortality Rate ⁵	TEENS (15-19)		Presumed Living with HIV/AIDS Rate ⁸	Asthma Discharge Rate (Age 0-4) ⁹	% Disabled 21-64 Years	% Disabled 65 Years+
					Pregnancy Rate ⁶	Birth Rate ⁷				
	United States			7.0	83.6	43.0	114.7	60.6	19.2	41.9
	New York State			5.9	57.4	31.7	530.7	66.1	21.0	40.3
	Nassau County			4.8	30.4	15.3	132.7	48.0	15.5	31.4
11575	Roosevelt	H	9.3	15.6	123.9	71.3	719.9	133.8	33.5	40.8
11550	Hempstead Village	H	8.8	9.4	76.5	46.1	542.2	174.0	24.9	38.6
11553	Uniondale	H	8.6	7.6	112.6	60.3	405.1	129.1	22.0	40.2
11096	Inwood	H	8.3	11.9	122.9	75.0	125.4	130.6	28.7	39.6
11520	Freeport	H	8.1	7.3	85.1	52.1	336.2	86.6	22.6	38.2
11050	Port Washington	H	NA	0.9	12.8	7.9	87.6	NA	13.7	27.4
11590	Westbury	H	7.6	7.5	89.3	54.4	272.9	90.2	22.1	37.1
11561	Long Beach	M	6.4	5.3	45.0	21.5	139.0	NA	19.9	38.8
11003	Elmont	M	7.0	8.1	47.1	20.8	153.1	81.1	22.7	40.2
11542	Glen Cove	M	NA	5.5	45.9	48.4	133.6	NA	15.3	32.8
11570	Rockville Centre	M	NA	3.0	29.8	12.6	150.9	NA	12.7	30.6
11554	East Meadow	M	NA	4.7	14.2	5.4	122.8	NA	14.2	30.6
11552	West Hempstead	M	NA	5.4	34.3	14.8	180.2	NA	13.6	32.0
11558	Island Park	M	NA	6.5	21.5	8.1	163.7	NA	13.6	30.8
11001	Floral Park	M	NA	3.3	21.6	6.9	70.6	NA	12.0	31.9

All data are from the U.S. Census 2000 except where noted.

¹The Community Needs Index (CNI) is a composite measure of ten variables (rates for AIDS cases, newborn seroprevalence, HIV hospital discharges and indicators of high risk behaviors such as teenage pregnancy, low birthweight, sexually transmitted diseases and drug-related hospital discharges). It was developed by the NYSDOH AIDS Institute as a tool to target zip codes for HIV prevention purposes (see Exhibit 1DEM 9).

²The 2000-2002 Perinatal Risk Assessment by Zip Code is an index from the NYSDOH Vital Statistics (based on % low birthweight, % out-of-wedlock births, % Medicaid births, % late/no prenatal care, infant mortality (death) rate, teen birth rate, teen pregnancy rate and total abortion ratios) to determine zip codes of need. The average decile ranking is 10.0 for most need and 0.0 for least need. (See Exhibit 1DEM 10).

³The Public Assistance Recipients Rank is based on the rate per 1,000 population for zip codes housing the most public assistance recipients. #1 has the most and #10 has the least on the top ten list (see Exhibit 1DEM 12).

⁴The Medicaid Eligible Recipients Rank is based on the rate per 1,000 population for zip codes housing the most Medicaid eligible recipients. #1 has the most and #10 has the least on the top ten list (see Exhibit 1DEM 13).

⁵The Infant Mortality Rate is the number of infant deaths under 1 year of age per 1,000 live births. The United States 2002 data are from the National Center for Health Statistics (NCHS). Nassau County and New York State are 2002 data and the zip code data are an average of 2000-2002 from the NYSDOH.

⁶The Teen Pregnancy Rate is the number of teen (age 15-19) pregnancies per 1,000 female population (age 15-19). Nassau County, New York State and the zip code data are an average of 2000-2002 from the NYSDOH. The U. S. data is an estimate by the Alan Guttmacher Institute, www.guttmacher.org.

⁷The Teen Birth Rate is the number of live births to women (age 15-19) per 1,000 female population (age 15-19). Nassau County, New York State and the zip code data are an average of 2000-2002 from the NYSDOH. The U.S. data are 2002.

⁸Rates for Nassau County, NYS and zip codes are based on data which are cumulative for cases diagnosed through December 31, 2003. HIV reporting began in June 2000. U.S. data are from the June 14, 2002 MMWR, 49(53), 1-102, "Summary of Notifiable Diseases in the United States, 2000".

⁹Nassau County, NYS and the zip code data are 2000-2002 average rate for asthma hospitalizations for 0-4 year olds. U.S. data is the estimated annual rate of physician office visits and hospital outpatient department visits in 1999 for asthma as the first-listed diagnosis in 0-4 year olds. National Ambulatory Medical Care Survey — United States, 1980–1999 and National Hospital Ambulatory Medical Care Survey — 1995–1999

Exhibit 1DEM 9

The Community Need Index (CNI) was developed to assist HIV prevention programs in targeting their efforts. The CNI is a composite measure that includes rates for AIDS cases, newborn seroprevalence, HIV hospital discharges and indicators of high risk behaviors such as teenage pregnancy, low birthweight, sexually transmitted diseases and drug-related hospital discharges. The ten variables included in the index are currently collected at the ZIP code level by the NYSDOH.

COMMUNITY NEED INDEX FOR NASSAU COUNTY

Risk Indicator Rates – HIV Infection/Illness Rates – AIDS Case Rates

25 Highest Ranking ZIP Codes

ZIP Code	Total ^b CNI Population		Risk Indicator Rates ^a					HIV Infection/Illness Rates ^a			AIDS Case Rates ^a		
			Low Birth-Weight	Teen Preg-nancy	Cocaine Discharges	Opioid Discharges	Sexually Transmitted Diseases	Newborn ^c Sero-prevalence	Male HIV Discharges	Female HIV Discharges	Men Who Have Sex With Men	AIDS Cases Other	Total AIDS Cases
			per 100	per 1,000	per 100,000	per 100,000	per 100,000	per 100	per 100,000	per 100,000	per 100,000	per 100,000	per 100,000
			Live Births	Females 10-17	Population 15-54	Population 15-54	Population	Tested Newborns	Males 15-54	Females 15-54	Males 15-54	Population 15-54	Population 15-54
11575	H	15,824	12.4	45.4	1,472	727	447	1.31	1,497	844	113	165	218
11550	H	51,204	10.0	46.1	1,100	559	351	0.64	1,003	580	59	90	118
11553	H	20,861	8.6	27.1	476	273	232	0.20	1,334	609	64	152	183
11096	H	6,552	8.3	30.8	848	550	137	0.93	587	303	20	93	103
11520	H	41,685	8.2	36.4	526	324	190	0.20	497	254	51	54	79
11050	H	26,998	6.5	8.3	1,153	728	22	0.09	340	281	9	13	17
11590	H	40,953	8.0	25.5	373	196	116	0.41	261	210	23	41	53
11561	M	40,317	6.4	14.8	394	431	46	0.07	307	78	26	24	37
11003	M	42,397	7.7	15.2	241	290	55	0.13	344	90	25	32	45
11542	M	25,018	6.6	16.8	368	372	40	0.09	302	39	5	15	17
11570	M	25,475	5.3	8.1	303	170	50	0.20	408	248	26	30	42
11554	M	36,390	6.6	6.4	597	315	11	0.16	253	117	12	13	19
11552	M	22,762	6.2	9.4	319	265	50	0.00	207	84	11	43	48
11558	M	9,730	6.4	6.2	277	277	10	0.00	359	233	*	*	35
11001	M	27,661	7.1	4.8	148	300	12	0.10	280	70	13	37	44
11020	L	5,634	5.6	6.5	225	154	41	0.00	126	202	*	*	47
11580	L	31,897	5.5	8.1	213	270	18	0.00	190	100	24	10	22
11579	L	5,454	4.0	9.7	97	227	12	0.60	0	88	*	*	11
11510	L	31,839	5.3	10.1	214	199	31	0.00	130	47	31	22	37
11709	L	6,917	7.8	4.9	177	177	5	0.00	156	17	16	16	24
11804	L	5,888	10.7	1.3	20	10	6	0.00	138	0	*	*	30
11710	L	34,332	7.0	5.0	161	172	13	0.00	197	14	28	10	24
11756	L	44,046	5.8	9.2	163	239	8	0.00	155	38	5	13	15
11568	L	4,301	11.0	4.3	37	62	16	0.00	0	0	*	*	12
11563	L	22,950	5.5	3.6	171	165	17	0.00	226	46	11	35	40
Regional References ^c													
80th Percentile			7.7	17.4	341	274	37	0.19	322	158	33	41	61
50th Percentile (Median)			5.7	7.3	168	138	12	0.00	126	31	10	13	21
Nassau County Rate			6.6	12.3	289	236	48	0.13	253	115	18	25	34
Total # of ZIP Codes that are at or above the 80th Percentile			15	6	10	11	12	10	10	10	8	8	6

^a Refer to glossary for definitions. ^b 1996 Population estimates are from Claritas Inc. ^c All newborns residing in a zip code area that has no reported parents may not have tested, nor all tests completed, therefore it is possible that one or more HIV-positive newborns may reside there. ^d The 80th percentile of an indicator rate is the score above which 20% of the ZIP codes do not follow county boundaries. ^e Bold indicates rates that are among the top twenty percent within their category in the CNI statistical area. ^f Underscore indicates rates that are based on small denominations and high data variability in a 3 year period.

Source: New York State Department of Health AIDS Institute

Exhibit 1DEM 10

**PERINATAL RISK ASSESSMENT BY ZIP CODE
NASSAU COUNTY
2000-2002**

Zip Code	Community	2000-2002				Vital Statistics Risk Indicators							Average Decile Rank**
		Total Pregnancies		Total Births		%LBW	%OOW	%MA	%PNC	Inf. Mort. Rate	Birth Rate	Preg. Rate	
		15-44	15-19	15-44	15-19						15-19	15-19	
11575	Roosevelt	1,398	219	896	126	10.2	62.1	47.8	8.0	15.6	71.3	123.9	9.3
11550	Hempstead	5,080	617	3,404	372	10.2	59.4	55.1	5.7	9.4	46.1	76.5	8.8
11553	Uniondale	1,707	194	1,182	106	8.9	47.9	40.1	4.3	7.6	47.8	87.5	8.6
11096	Inwood	429	61	335	36	9.6	44.2	42.5	7.6	11.9	49.2	83.4	8.3
11520	Freeport	2,855	320	2,049	194	9.7	46.6	40.4	4.5	7.3	46.7	77.1	8.1
11590	Westbury	2,737	306	2,134	188	7.7	40.3	42.1	3.4	7.5	49.3	80.2	7.6
11003	Elmont	2,148	144	1,607	65	7.8	29.2	26.9	5.3	8.1	16.7	37.1	7.0
11561	Long Beach	1,718	116	1,313	53	9.5	20.9	16.3	4.1	5.3	21.6	47.2	6.4
Nassau County		58,393	3,981	47,866	1,708	7.6	18.6	20.0	2.5	5.2	15.3	30.4	
New York State		1,014,253	125,142	1,080,275	59,120	7.8	36.3	41.3	6.2	6.0	31.7	57.4	

*Age-specific comparison of pregnancy, birth count and vital statistics risk indicators for Upstate NY zip codes with 100+ pregnancies in 2000-2002.

**Decile Rank based on % Low birthweight, % Out-of-wedlock births, % Medicaid births, % Late/no prenatal care, Infant mortality rate, Teen birth rate, Teen pregnancy rate and Total abortion ratios.

Source: New York State Department of Health Vital Statistics

PUBLIC ASSISTANCE RECIPIENTS IN NASSAU COUNTY
2001-2003

COMMUNITY	RECIPIENTS			TOTAL 2001-2003	% of TOTAL	AVG. YEARLY RATE*	RANK
	2001	2002	2003				
Hempstead	2,474	2,196	2,260	6,930	25.7%	39.1	2
Roosevelt	901	828	989	2,718	11.2%	56.7	1
Freeport	763	780	872	2,415	9.9%	18.4	4
Westbury	562	538	592	1,692	6.7%	13.3	5
Uniondale	422	480	437	1,339	5.0%	19.4	3
Long Beach	347	286	358	991	4.1%	8.4	6
Elmont	219	214	253	686	2.9%	5.7	9
Inwood	240	196	197	633	2.2%	8.3	7
Glen Cove	173	165	184	522	2.1%	6.3	8
Baldwin	152	141	162	455	1.8%	4.7	10
SELECTED COMMUNITIES	6,253	5,824	6,304	18,381	71.6%	18.0	
Rest of County	2,180	2,100	2,496	6,776	28.4%	2.3	
NASSAU COUNTY	8,433	7,924	8,800	25,157	100.0%	6.3	

*Per 1,000 population (U.S. Census 2000)

Source: Nassau County Department of Social Services

Exhibit 1DEM 12

**MEDICAID ELIGIBLE RECIPIENTS* IN NASSAU COUNTY
2001-2003**

COMMUNITY	RECIPIENTS			TOTAL 2001-2003	%of TOTAL	AVG. YEARLY RATE**	RANK
	2001	2002	2003				
Hempstead	10,050	10,134	13,646	33,830	15.3%	191.1	2
Freeport	5,036	5,225	7,580	17,841	8.1%	135.8	4
Westbury	3,634	3,760	5,675	13,069	5.9%	102.5	5
Uniondale	2,995	3,183	4,493	10,671	4.8%	154.6	3
Roosevelt	2,944	3,089	4,050	10,083	4.6%	210.4	1
Long Beach	2,918	2,903	3,525	9,346	4.2%	78.7	7
Elmont	2,451	2,613	4,001	9,065	4.1%	74.6	8
Valley Stream	1,790	2,005	3,445	7,240	3.3%	63.9	10
Glen Cove	1,803	1,771	2,487	6,061	2.7%	73.0	9
Great Neck	1,331	1,392	2,004	4,727	2.1%	79.5	6
SELECTED COMMUNITIES	34,952	36,075	50,906	121,933	55.2%	116.2	
Rest of County	27,846	29,561	41,413	98,820	44.8%	33.5	
NASSAU COUNTY	62,798	65,636	92,319	220,753	100.0%	55.1	

*Includes all Public Assistance and Medical Assistance Categories

**Per 1,000 population (U.S. Census 2000)

Source: Nassau County Department of Social Services

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Exhibit 2BIR 1

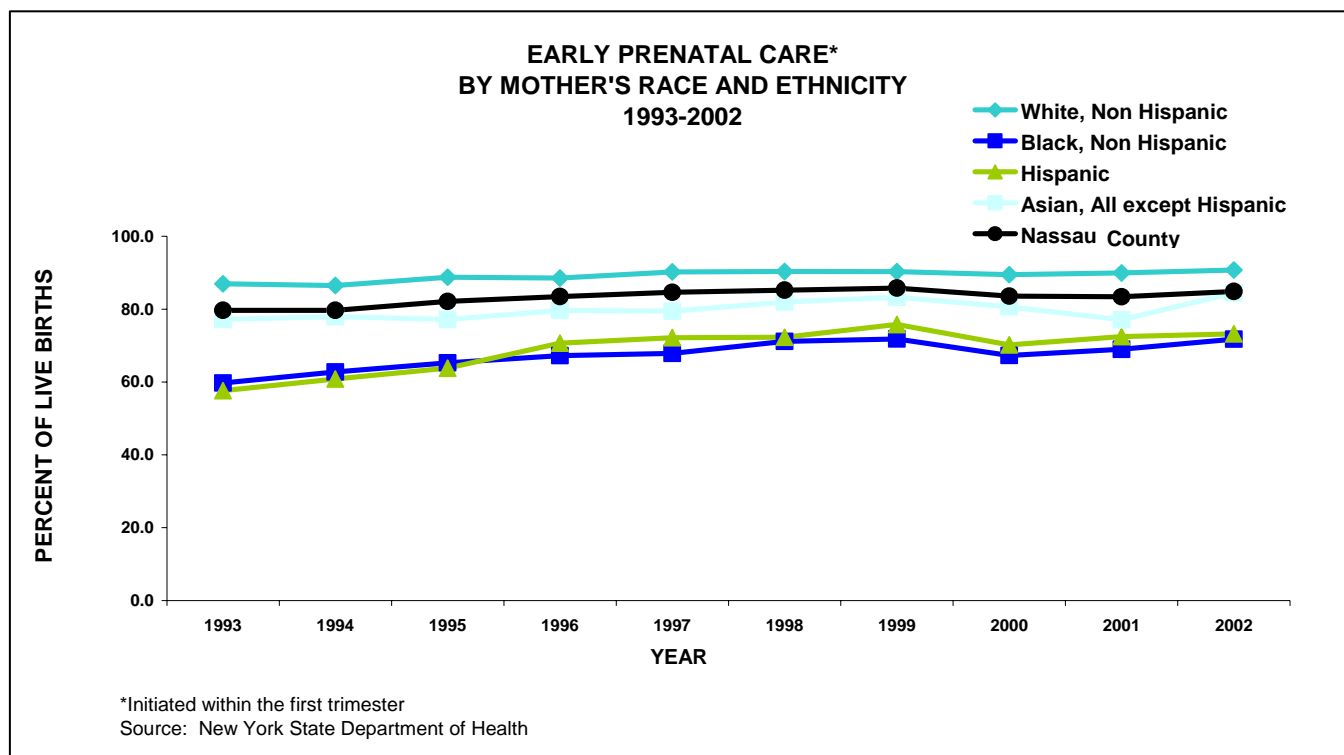


Exhibit 2BIR 2

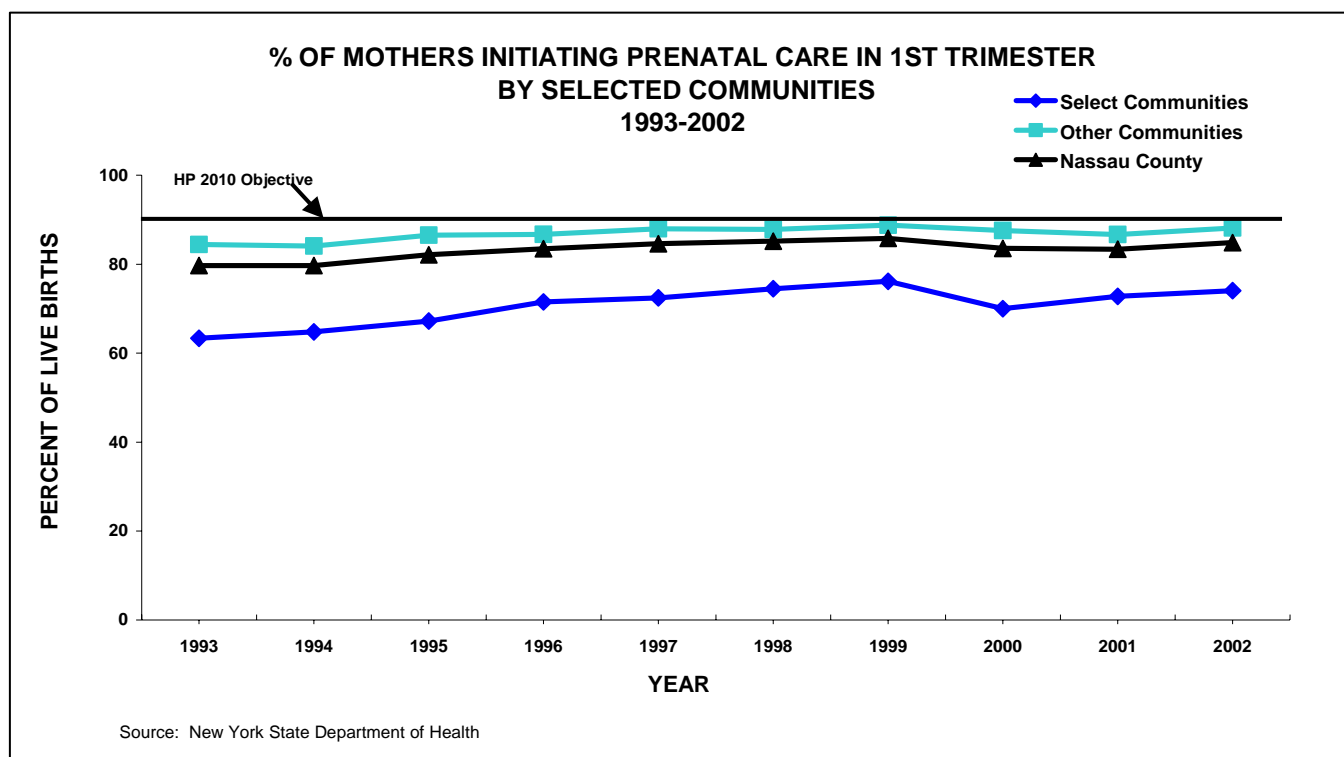


Exhibit 2BIR 3

**BIRTHS WITH EARLY PRENATAL CARE* IN NASSAU COUNTY
BY MOTHER'S AGE AND RACE
1985-2002**

NUMBER OF BIRTHS WITH EARLY PRENATAL CARE BY AGE AND RACE

YEAR	AGE < 20				AGE 20 +				ALL AGES			
	WHITE	BLACK	OTHER	TOTAL	WHITE	BLACK	OTHER	TOTAL	WHITE	BLACK	OTHER	TOTAL
1985	177	179	2	358	11,713	986	281	12,980	11,890	1,165	283	13,338
1990	245	169	1	415	13,975	1,366	473	15,814	14,220	1,535	474	16,229
1995	219	138	5	362	12,605	1,308	576	14,489	12,824	1,446	552	14,851
1996	211	133	5	349	12,545	1,286	611	14,442	12,756	1,419	598	14,791
1997	200	108	8	316	12,217	1,278	657	14,152	12,420	1,386	665	14,471
1998	233	126	8	367	12,150	1,436	689	14,275	12,383	1,562	697	14,642
1999	226	117	4	349	12,045	1,440	674	14,182	12,271	1,557	678	14,531
2000	207	93	5	305	11,707	1,396	739	13,885	11,914	1,489	744	14,190
2001	200	106	5	312	11,131	1,363	714	13,246	11,331	1,469	719	13,558
2002	213	100	11	324	11,211	1,369	936	13,540	11,424	1,469	947	13,864

PERCENT OF ALL BIRTHS WITH EARLY PRENATAL CARE BY AGE AND RACE

YEAR	AGE < 20				AGE 20 +				ALL AGES			
	WHITE	BLACK	OTHER	TOTAL	WHITE	BLACK	OTHER	TOTAL	WHITE	BLACK	OTHER	TOTAL
1985	55.7	46.4	28.6	49.8	91.9	67.5	84.4	89.3	91.0	63.1	83.2	87.3
1990	67.1	55.4	25.0	61.1	92.9	72.2	83.3	90.3	92.2	69.3	82.9	89.1
1995	57.0	52.9	45.5	55.2	89.0	71.3	80.9	86.7	88.2	69.0	80.3	85.5
1996	56.9	55.2	83.3	56.5	89.2	72.7	83.8	87.2	88.4	70.6	83.9	86.1
1997	58.0	49.5	72.7	55.0	88.0	70.3	82.4	85.6	89.4	70.2	83.9	86.9
1998	59.2	51.9	53.3	56.0	88.4	73.9	85.1	86.4	89.8	73.6	84.0	87.5
1999	64.4	54.7	33.3	60.2	88.7	74.4	83.4	86.7	89.8	74.7	85.3	87.7
2000	55.3	46.5	41.7	52.0	87.1	70.2	80.3	84.7	86.3	68.1	79.8	83.6
2001	57.1	50.7	45.5	54.6	86.9	71.2	77.4	84.4	86.1	69.2	77.1	83.4
2002	60.2	49.0	57.9	56.1	87.8	74.2	84.6	85.9	87.0	71.7	84.2	84.9

*Mothers who received care during the first three months of pregnancy

Totals may include unknowns.

Source: New York State Department of Health

Exhibit 2BIR 4

**BIRTHS IN NASSAU COUNTY WITH EARLY PRENATAL CARE TO MOTHERS < 20
BY SELECTED COMMUNITIES
1980-2002**

NUMBER OF BIRTHS WITH EARLY PRENATAL CARE TO MOTHERS UNDER 20

YEAR	SELECTED COMMUNITIES							TOTAL		
	11520 Freeport	11550 Hempstead	11096 Inwood	11561 Long Beach	11590 Westbury	11575 Roosevelt	11553 Uniondale	Selected Communities	Rest of County	Nassau County
1980	48	50	7	19	7	37	NA	168	165	333
1985	45	62	6	27	15	29	NA	184	166	350
1990	40	80	3	14	26	47	NA	210	197	407
1995	46	84	6	18	22	30	17	223	142	365
1996	39	69	5	11	31	25	20	200	154	354
1997	53	52	7	17	17	22	23	191	128	319
1998	49	83	4	18	35	22	19	230	137	367
1999	45	73	3	13	36	20	17	207	142	349
2000	31	76	5	6	40	17	18	193	112	305
2001	43	60	5	9	39	27	25	208	104	312
2002	36	69	5	12	41	17	22	202	122	324

PERCENT OF ALL BIRTHS WITH EARLY PRENATAL CARE TO MOTHERS UNDER 20

YEAR	SELECTED COMMUNITIES							TOTAL		
	11520 Freeport	11550 Hempstead	11096 Inwood	11561 Long Beach	11590 Westbury	11575 Roosevelt	11553 Uniondale	Selected Communities	Rest of County	Nassau County
1980	48.5	45.4	66.7	63.3	29.2	58.1	NA	49.4	48.4	48.9
1985	57.0	45.3	37.5	58.7	32.6	47.5	NA	47.8	52.2	49.8
1990	53.3	60.6	75.0	66.7	60.5	62.7	NA	60.0	62.3	61.1
1995	56.1	53.9	54.5	72.0	37.9	62.5	51.5	54.0	57.3	55.2
1996	57.4	59.0	55.6	52.4	50.0	53.2	62.5	55.9	57.5	56.7
1997	57.6	51.0	50.0	63.0	50.0	53.7	59.0	54.6	56.1	55.2
1998	62.0	61.5	50.0	56.3	61.4	43.1	51.4	57.6	53.5	56.0
1999	68.2	59.3	27.3	52.0	66.7	54.1	53.1	59.5	61.2	60.2
2000	50.0	58.5	45.5	35.3	56.3	44.7	52.9	53.2	50.0	51.9
2001	58.1	53.6	41.7	56.3	62.9	54.0	73.5	57.8	49.3	54.6
2002	60.0	50.7	38.5	54.5	70.7	40.5	57.9	54.7	58.4	56.1

Communities are defined by zip codes beginning with 1990. Prior to 1990, the communities are described by census tract.

Source : New York State Department of Health

Exhibit 2BIR 5

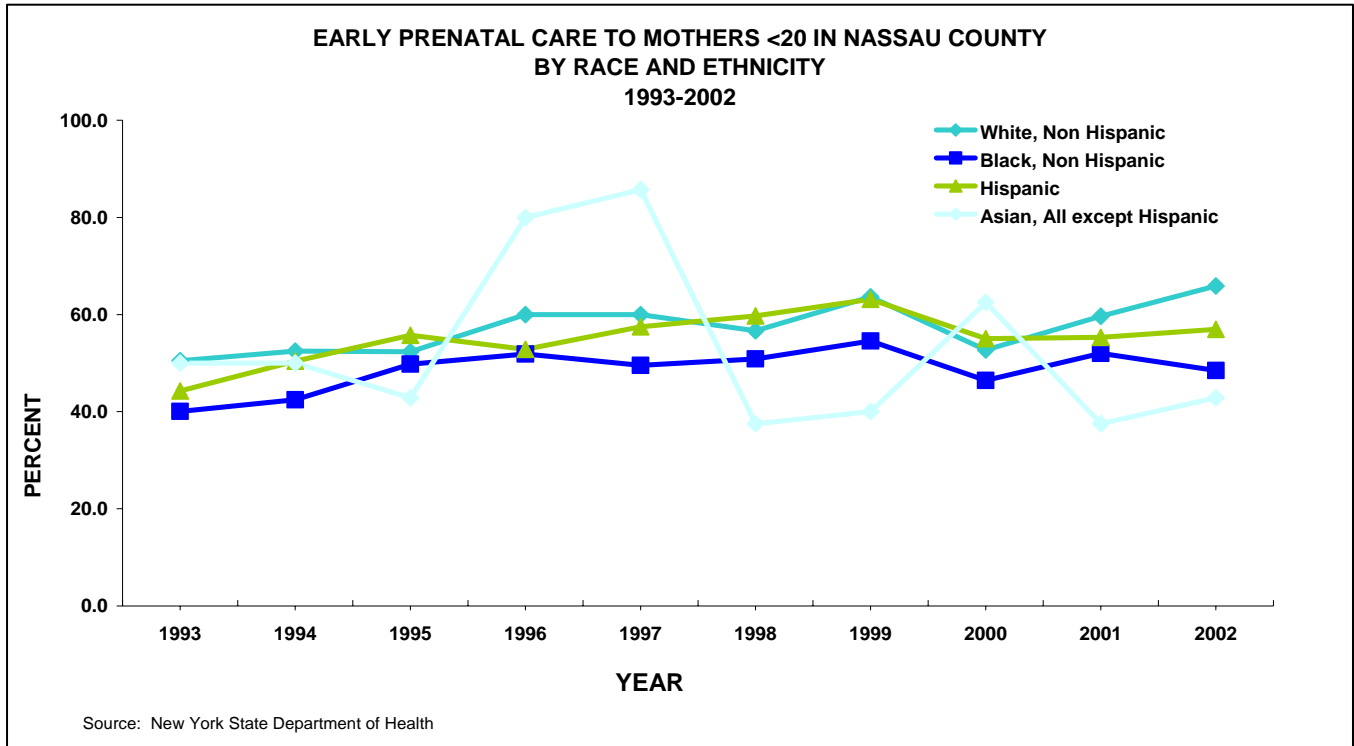
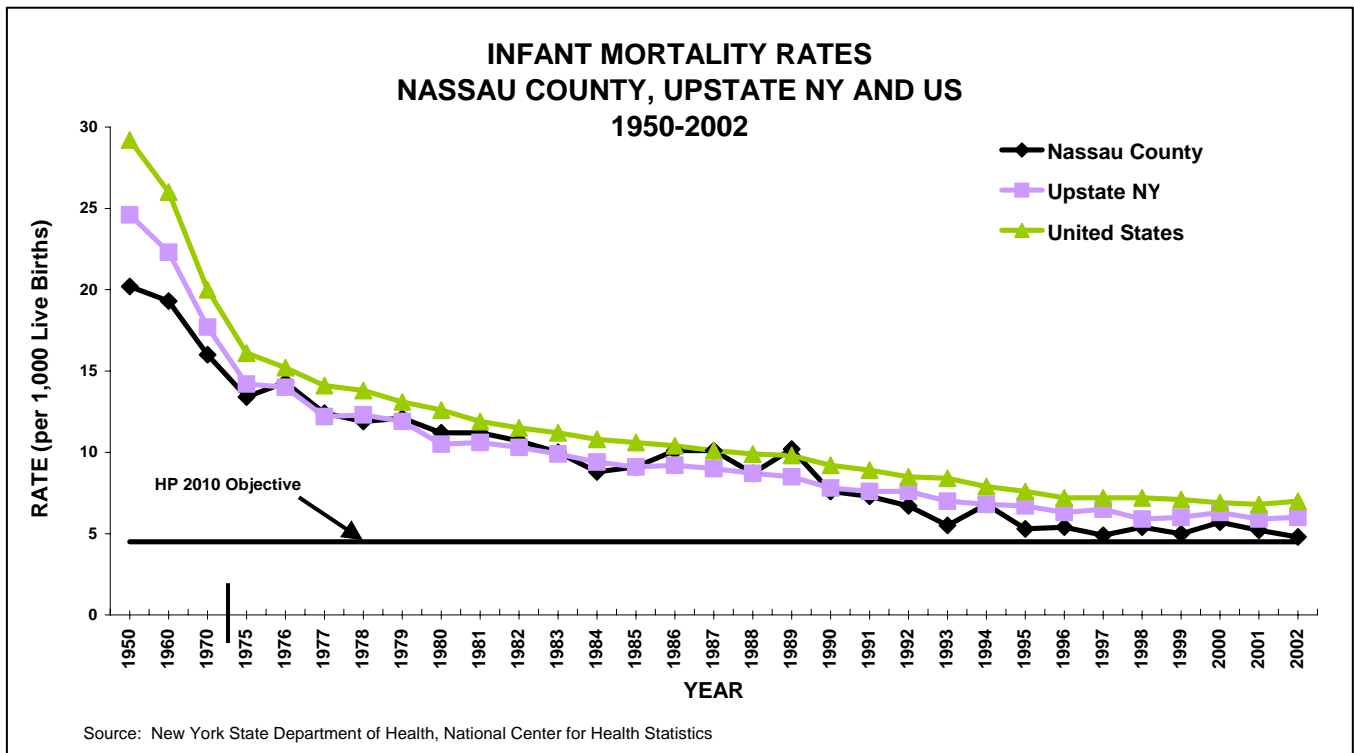


Exhibit 2BIR 6



**INFANT MORTALITY RATES BY RACE AND HISPANIC ORIGIN
NASSAU COUNTY AND UNITED STATES
1975-2002**

2010 Objective = 4.5*

YEAR	WHITE		BLACK		ALL RACES**		HISPANIC	
	Nassau County	United States	Nassau County	United States	Nassau County	United States	Nassau County	United States
1975	11.3	14.2	29.1	26.2	13.4	16.1	NA	NA
1976	12.2	13.3	32.0	25.5	14.3	15.2	NA	NA
1977	10.3	12.3	30.7	23.6	12.4	14.1	NA	NA
1978	9.4	12.0	33.3	23.1	11.9	13.8	NA	NA
1979	9.6	11.4	32.5	21.8	12.1	13.1	NA	NA
1980	9.6	11.0	24.7	21.4	11.2	12.6	NA	NA
1981	9.1	10.5	29.1	20.0	11.2	11.9	NA	NA
1982	8.3	10.1	27.7	19.6	10.7	11.5	NA	NA
1983	8.5	9.7	22.1	19.2	10.0	11.2	NA	9.5
1984	6.8	9.4	22.7	18.4	8.8	10.8	NA	NA
1985	7.2	9.3	22.4	18.2	9.1	10.6	NA	8.8
1986	8.0	8.9	25.4	18.0	10.1	10.4	NA	NA
1987	7.0	8.6	31.2	17.9	10.1	10.1	NA	NA
1988	6.6	8.4	23.3	18.5	8.7	9.9	NA	NA
1989	7.8	8.1	26.6	18.6	10.2	9.8	NA	NA
1990	5.7	7.6	21.8	18.0	7.6	9.2	NA	7.5
1991	5.9	7.3	15.7	17.6	7.3	8.9	6.9	NA
1992	4.9	6.9	18.2	16.8	6.7	8.5	4.7	NA
1993	4.0	6.8	15.1	16.5	5.5	8.4	5.1	NA
1994	4.6	6.6	21.4	15.8	6.8	7.9	4.1	NA
1995	4.2	6.3	13.1	15.1	5.3	7.6	6.7	6.3
1996	3.8	6.0	16.7	14.2	5.4	7.2	5.6	6.1
1997	3.2	6.0	15.2	14.2	4.9	7.2	5.5	6.0
1998	3.9	6.0	15.1	14.3	5.4	7.2	6.7	5.8
1999	4.0	5.8	11.6	14.6	5.0	7.1	6.2	5.7
2000	4.4	5.7	12.8	14.1	5.7	6.9	5.7	5.6
2001	4.3	5.7	11.8	14.0	5.2	6.8	5.1	5.4
2002	3.7	5.8	12.2	14.4	4.8	7.0	6.3	5.6

*Rates are per 1,000 live births.

**Includes unknown and other races.

NA = No available data.

Source: NYSDOH Vital Statistics and National Center for Health Statistics

Exhibit 2BIR 8

**INFANT MORTALITY RATES BY REGION
NASSAU COUNTY, OTHER COUNTIES, UPSTATE NY, NYS AND THE US
1950-2002**

2010 Objective = 4.5*

YEAR	NASSAU COUNTY		WESTCHESTER	SUFFOLK	NYC	UPSTATE NY	NYS	US
	#	RATE						
1950	334	20.2	NA	NA	25.0	24.6	24.8	29.2
1955	467	18.3	NA	NA	26.5	22.5	24.3	NA
1960	487	19.3	NA	NA	26.3	22.3	24.1	26.0
1965	406	19.3	NA	NA	25.8	21.3	23.4	NA
1970	276	15.9	18.2	17.7	21.8	17.7	19.6	20.0
1975	170	13.4	15.0	11.4	17.9	14.2	15.8	16.1
1976	187	14.3	12.7	12.4	18.1	14.0	15.8	15.2
1977	160	12.4	11.8	10.0	17.0	12.2	14.3	14.1
1978	154	11.9	11.3	11.9	16.0	12.3	13.9	13.8
1979	163	12.2	11.1	10.3	15.7	11.9	13.5	13.1
1980	154	11.4	10.2	9.6	15.1	10.5	12.5	12.6
1981	159	11.4	10.9	8.8	14.5	10.6	12.3	11.9
1982	154	10.7	11.0	8.7	14.5	10.3	12.2	11.5
1983	144	9.9	9.3	9.0	13.6	9.9	11.5	11.2
1984	127	8.7	9.9	8.7	12.8	9.4	10.9	10.8
1985	139	9.1	9.2	9.9	12.8	9.1	10.7	10.6
1986	150	9.6	8.6	7.4	12.4	9.2	10.6	10.4
1987	169	10.2	9.2	7.8	12.7	9.0	10.7	10.1
1988	149	8.7	8.4	8.0	13.2	8.7	10.7	9.9
1989	180	10.2	9.1	8.1	13.1	8.5	10.6	9.8
1990	138	7.6	7.1	8.4	11.5	7.8	9.5	9.2
1991	130	7.3	6.5	7.2	11.3	7.6	9.3	8.9
1992	121	6.7	6.3	6.6	10.0	7.6	8.7	8.5
1993	98	5.5	7.1	5.5	9.8	7.0	8.3	8.4
1994	121	6.8	6.1	5.9	8.7	6.8	7.7	7.9
1995	95	5.3	5.4	6.4	8.6	6.7	7.6	7.6
1996	96	5.4	4.5	5.1	7.7	6.3	6.9	7.2
1997	83	4.9	5.1	6.2	7.0	6.5	6.7	7.2
1998	93	5.4	5.2	4.7	6.6	5.9	6.2	7.2
1999	85	5.0	4.2	5.9	6.6	6.0	6.3	7.1
2000	97	5.7	4.9	4.6	6.3	6.3	6.3	6.9
2001	84	5.2	3.8	4.6	5.6	5.9	5.7	6.8
2002	79	4.8	4.5	5.1	5.8	6.0	5.9	7.0

*Rates are per 1,000 live births

Source : NYSDOH and Center for Health Statistics

APPENDIX 3 - Teen Pregnancy and Family Planning

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TEEN BIRTH AND PREGNANCY RATES*
NASSAU COUNTY, UPSTATE NEW YORK AND UNITED STATES
1980-2002

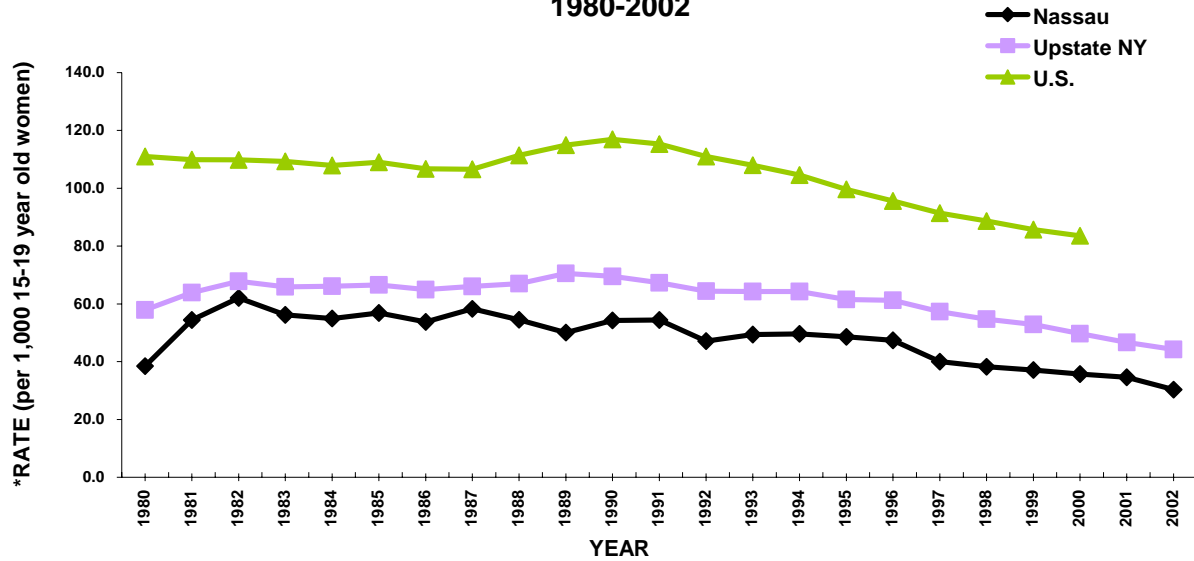
YEAR	BIRTH RATES			PREGNANCY RATES	
	NASSAU	UPSTATE	US	NASSAU	UPSTATE
1980	10.6	27.2	53.0	38.5	57.9
1981	11.8	28.0	52.2	54.4	63.9
1982	13.2	29.1	52.4	62.1	67.8
1983	13.9	29.4	51.4	56.2	65.9
1984	12.8	29.2	50.6	54.9	66.1
1985	14.1	29.7	51.0	56.9	66.6
1986	13.9	29.5	50.2	53.8	64.9
1987	14.3	30.0	50.6	58.3	66.0
1988	14.7	31.4	53.0	54.5	67.0
1989	15.8	33.5	57.3	50.0	70.5
1990	16.5	34.4	60.3	54.3	69.5
1991	16.6	34.7	59.0	54.4	67.3
1992	15.8	33.5	58.2	47.1	64.4
1993	18.4	34.2	59.0	49.4	64.3
1994	18.2	34.5	58.2	49.6	64.3
1995	18.0	32.9	56.0	48.6	61.5
1996	16.8	32.2	53.5	47.4	61.2
1997	15.2	30.5	51.3	40.0	57.3
1998	17.2	30.6	50.3	38.2	54.7
1999	15.1	29.7	48.8	37.1	52.9
2000	14.5	27.5	47.7	35.7	49.7
2001	14.1	26.0	45.3	34.6	46.7
2002	13.7	24.4	42.9	30.3	44.2

*Rates per 1,000 women between 15 and 19 years old.

Source : New York State Department of Health

Exhibit 3TPFP 2

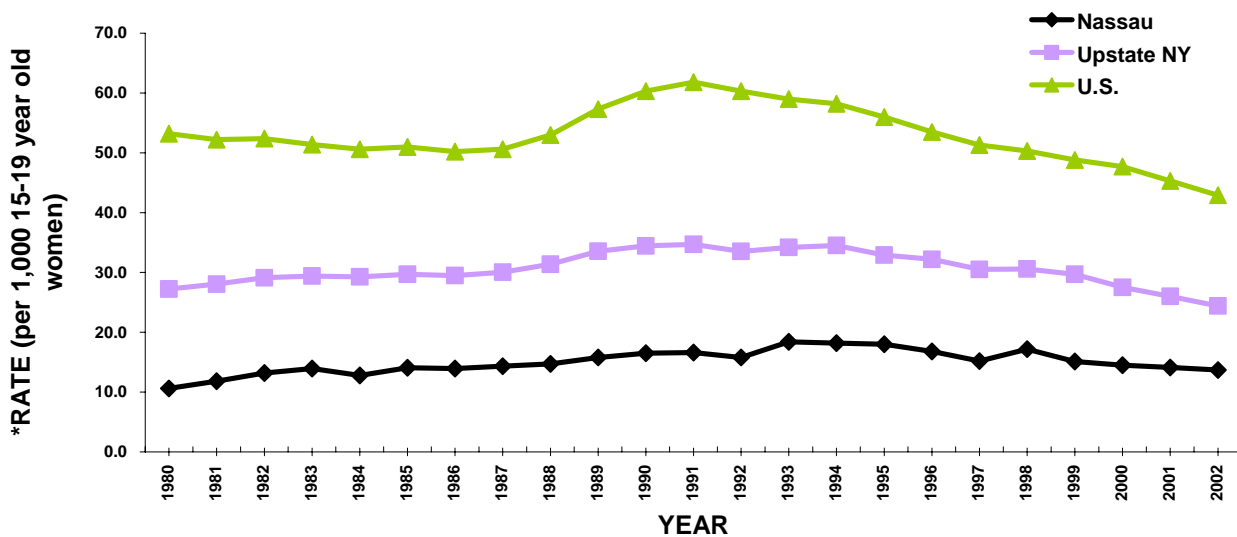
TEEN PREGNANCY RATES*
NASSAU COUNTY, UPSTATE NY AND US
1980-2002



Source: New York State Department of Health and National Center for Health Statistics

Exhibit 3TPFP 3

TEEN BIRTH RATES*
NASSAU COUNTY, UPSTATE NY AND US
1980-2002



Source: New York State Department of Health and National Center for Health Statistics

Exhibit 3TPFP 4

**TEEN* PREGNANCY OUTCOMES
NASSAU COUNTY
1980-2002**

YEAR	LIVE BIRTHS	%	ITOPS	%	TOTAL PREGNANCIES
1980	678	27.4%	1,726	69.8%	2,474
1981	702	21.3%	2,487	75.5%	3,293
1982	754	22.4%	2,515	74.7%	3,366
1983	776	24.8%	2,281	72.8%	3,135
1984	674	23.2%	2,172	74.9%	2,900
1985	711	24.2%	2,151	73.1%	2,942
1986	685	25.7%	1,902	71.3%	2,666
1987	677	24.4%	2,032	73.4%	2,770
1988	663	26.7%	1,785	71.8%	2,487
1989	679	31.5%	1,444	67.0%	2,155
1990	674	29.9%	1,543	68.4%	2,257
1991	672	30.4%	1,498	67.8%	2,208
1992	629	33.6%	1,207	64.4%	1,874
1993	725	37.4%	1,167	60.3%	1,936
1994	697	37.0%	1,141	60.5%	1,885
1995	685	36.9%	1,122	60.4%	1,857
1996	637	35.4%	1,126	62.6%	1,800
1997	575	37.5%	917	59.8%	1,533
1998	655	44.8%	764	52.3%	1,461
1999	580	40.8%	815	57.3%	1,422
2000	587	40.5%	836	57.7%	1,448
2001	571	40.4%	812	57.4%	1,415
2002	578	45.2%	670	52.3%	1,280

*Teens: Females under 20 years old

ITOPS : Induced termination of pregnancies

STOPS : Spontaneous termination of pregnancies

Source : New York State Department of Health

Exhibit 3TPFP 5

PREGNANCY OUTCOMES* BY AGE AND RACE
NASSAU COUNTY
2002

RACE	AGE													
	UNDER 20		20-24		25-29		30-34		35-39		40 +		ALL AGES	
	NUMBER	%	NUMBER	%	NUMBER	%	NUMBER	%	NUMBER	%	NUMBER	%	NUMBER	%
INDUCED TERMINATIONS OF PREGNANCIES														
WHITE	257	41.1	390	24.7	254	8.1	217	3.8	190	5.1	83	8.8	1,391	8.8
BLACK	222	50.6	307	40.6	214	31.1	164	22.0	118	22.0	37	21.4	1,062	31.8
OTHER	34	61.8	34	26.0	23	6.6	32	6.6	27	9.9	14	21.5	164	12.1
TOTAL**	670	52.3	1,040	37.3	695	15.8	575	8.1	428	9.2	177	14.3	3,585	16.7
LIVE BIRTHS														
WHITE	354	56.5	1,125	71.1	2,699	86.2	5,121	89.9	3,162	84.6	668	70.5	13,129	83.5
BLACK	204	46.5	425	56.1	440	64.0	522	69.9	355	66.2	102	59.0	2,048	61.3
OTHER	19	34.5	91	69.5	318	91.1	422	87.2	232	84.7	43	66.2	1,125	82.8
TOTAL**	578	45.2	1,647	59.1	3,465	79.0	6,077	85.5	3,755	80.6	814	65.9	16,336	76.2
SPONTANEOUS TERMINATIONS OF PREGNANCIES														
WHITE	15	2.4	67	4.2	179	5.7	357	6.3	386	10.3	197	20.8	1,201	7.6
BLACK	13	3.0	25	3.3	34	4.9	61	8.2	63	11.8	34	19.7	230	6.9
OTHER	2	3.6	6	4.6	8	2.3	30	6.2	15	5.5	8	12.3	69	5.1
TOTAL**	32	2.5	98	3.5	225	5.1	457	6.4	475	10.2	244	19.8	1,531	7.1
TOTAL PREGNANCIES														
WHITE	626		1,582		3,132		5,695		3,738		948		15,721	
BLACK	439		757		688		747		536		173		3,340	
OTHER	55		131		349		484		274		65		1,358	
TOTAL**	1,280		2,785		4,385		7,109		4,658		1,235		21,452	

* Numbers and percentages of total outcomes for that age and race

**Note that totals include unknowns and may be greater than the sum of the categories

Source: New York State Department of Health

Exhibit 3TPFP 6

**ALL PREGNANCY OUTCOMES
NASSAU COUNTY
1980-2002**

YEAR	LIVE BIRTHS	%	ITOPS	%	STOPS	%	TOTAL PREGNANCIES
1980	13,539	60.8%	7,389	33.2%	1,327	6.0%	22,255
1981	13,957	55.8%	9,547	38.2%	1,489	6.0%	24,993
1982	14,387	55.5%	9,979	38.5%	1,541	6.0%	25,907
1983	14,551	59.0%	8,767	35.5%	1,357	5.5%	24,675
1984	14,833	60.1%	8,573	34.7%	1,285	5.2%	24,691
1985	15,247	60.4%	8,526	33.8%	1,452	5.8%	25,225
1986	15,567	61.6%	8,185	32.4%	1,510	6.0%	25,262
1987	16,504	63.4%	8,154	31.3%	1,393	5.3%	26,051
1988	17,072	65.8%	7,592	29.3%	1,290	5.0%	25,954
1989	17,700	67.9%	6,903	26.5%	1,464	5.6%	26,067
1990	18,180	66.7%	7,653	28.1%	1,407	5.2%	27,240
1991	17,864	66.1%	7,861	29.1%	1,295	4.8%	27,020
1992	18,065	68.6%	6,893	26.2%	1,379	5.2%	26,337
1993	17,931	68.2%	6,717	25.5%	1,657	6.3%	26,305
1994	17,903	69.2%	6,388	24.7%	1,582	6.1%	25,873
1995	18,084	70.3%	6,129	23.8%	1,501	5.9%	25,714
1996	17,722	71.5%	5,723	23.1%	1,332	5.4%	24,777
1997	17,100	73.0%	4,971	21.2%	1,370	5.8%	23,441
1998	17,186	75.6%	4,136	18.2%	1,399	6.2%	22,721
1999	16,935	75.0%	4,205	18.6%	1,431	6.3%	22,571
2000	16,979	73.5%	4,754	18.6%	1,380	6.0%	23,113
2001	16,260	74.4%	4,227	20.6%	1,364	6.2%	21,851
2002	16,336	76.2%	3,585	19.3%	1,531	7.1%	21,452

ITOPS : Induced termination of pregnancies

STOPS : Spontaneous termination of pregnancies

Source : New York State Department of Health

Exhibit 3TPFP 7

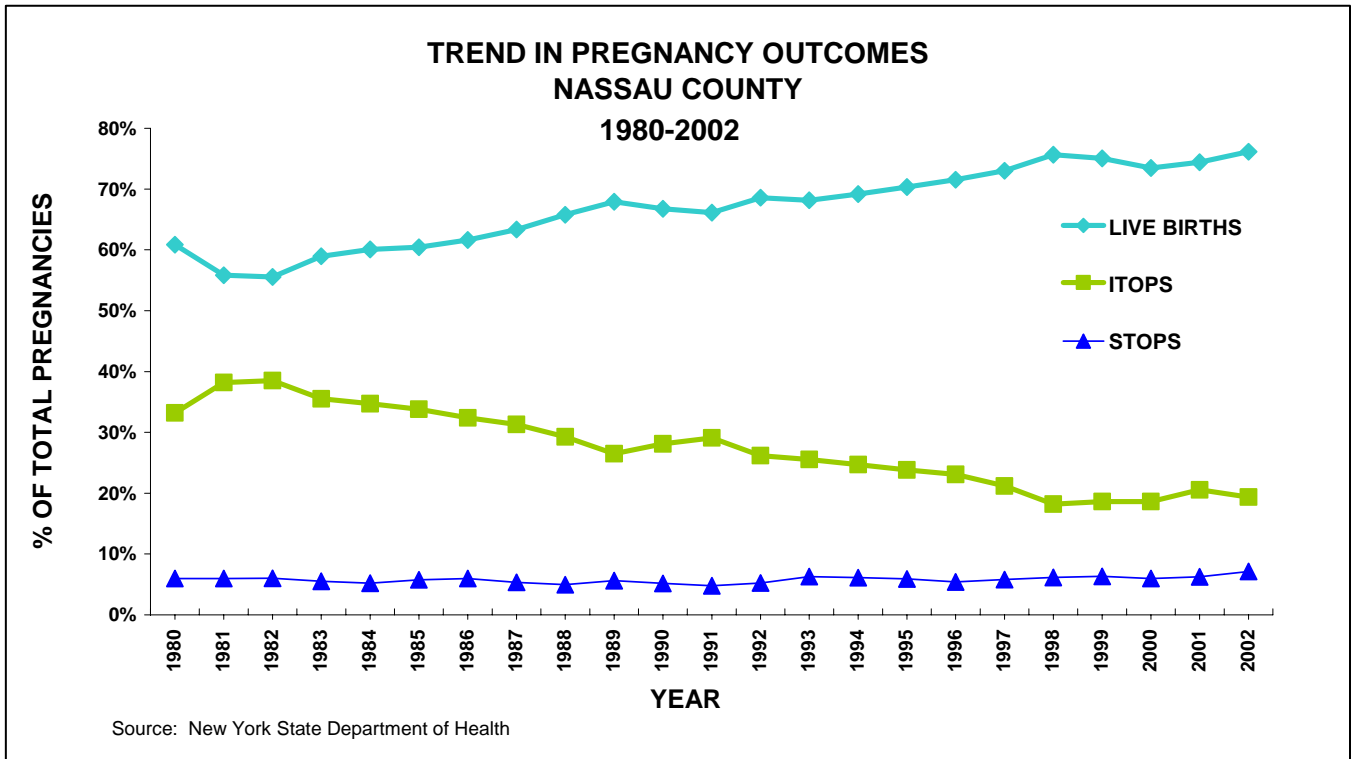
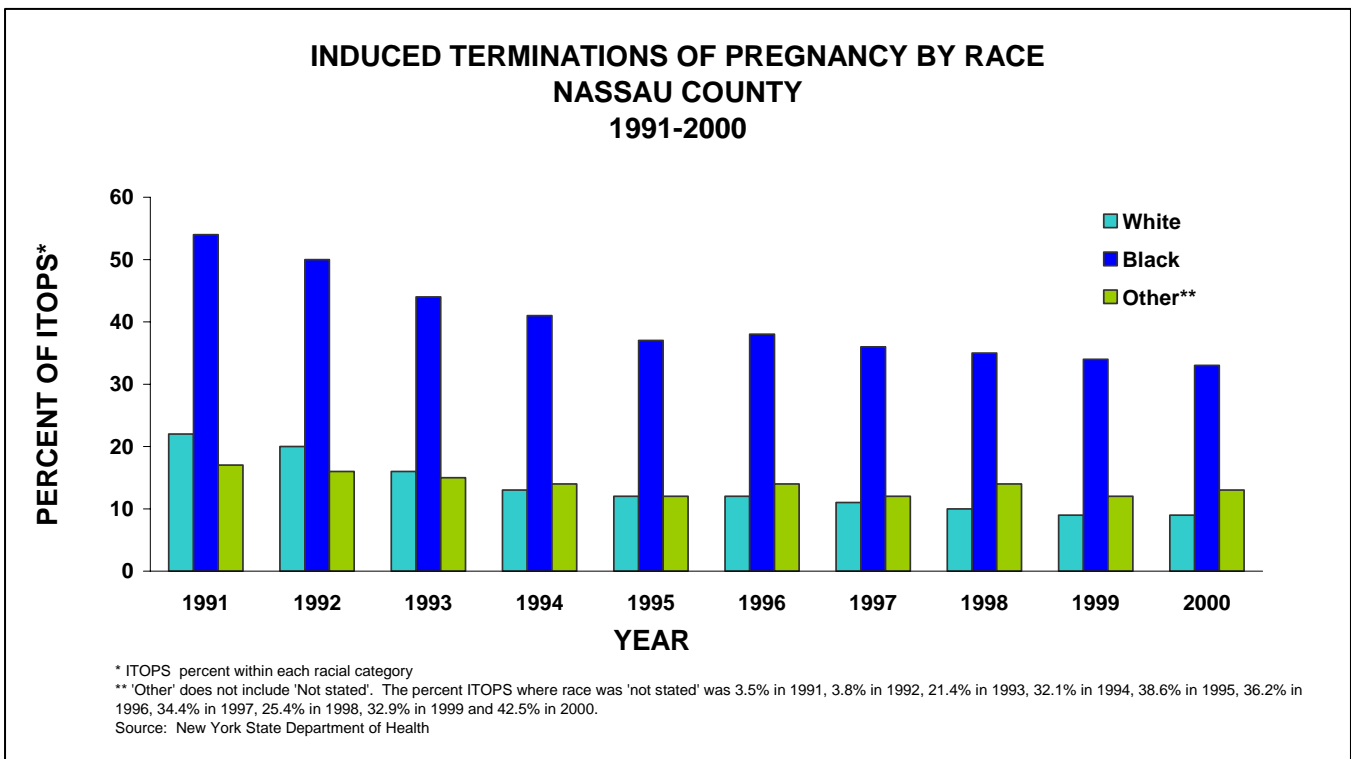


Exhibit 3TPFP 8



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Recommended Childhood and Adolescent Immunization Schedule UNITED STATES • 2005

Vaccine ▼ Age ►	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	24 months	4-6 years	11-12 years	13-18 years
Hepatitis B	HepB #1		HepB #2			HepB #3				HepB Series		
Diphtheria, Tetanus, Pertussis			DTaP	DTaP	DTaP		DTaP			DTaP	Td	Td
<i>Haemophilus influenzae</i> type b			Hib	Hib	Hib		Hib					
Inactivated Poliovirus			IPV	IPV		IPV			IPV			
Measles, Mumps, Rubella						MMR #1			MMR#2		MMR #2	
Varicella						Varicella			Varicella			
Pneumococcal Conjugate			PCV	PCV	PCV	PCV			PCV	PPV		
Influenza						Influenza (Yearly)			Influenza (Yearly)			
Hepatitis A									Hepatitis A Series			

This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of December 1, 2004, for children through age 18 years. Any dose not given at the recommended age should be given at any subsequent visit when indicated and feasible.

Indicates age groups that warrant special effort to administer those vaccines not previously given. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and the vaccine's other components are not contraindicated. Providers should consult the manufacturers' package inserts for detailed recommendations. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete a VAERS form can be found on the Internet: www.vaers.org or by calling 800-822-7967.

Range of recommended ages
Preadolescent assessment

Only if mother HBsAg(–)
Catch-up immunization



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION
The Childhood and Adolescent Immunization Schedule



Is approved by:
Advisory Committee on Immunization Practices www.cdc.gov/nip/acip
American Academy of Pediatrics www.aap.org
American Academy of Family Physicians www.aafp.org

More information regarding vaccine administration can be obtained from the websites above or by calling

800-CDC-INFO
ENGLISH & ESPAÑOL
[800-232-4636]

Keep track of your child's immunizations with the

CDC Childhood Immunization Scheduler
www.cdc.gov/nip/kidstuff/scheduler.htm

Recommended Immunization Schedule for Children and Adolescents Who Start Late or Are More Than 1 Month Behind UNITED STATES • 2005

The tables below give catch-up schedules and minimum intervals between doses for children who have delayed immunizations. There is no need to restart a vaccine series regardless of the time that has elapsed between doses. Use the chart appropriate for the child's age.

CATCH-UP SCHEDULE FOR CHILDREN AGED 4 MONTHS THROUGH 6 YEARS

VACCINE	MINIMUM AGE FOR DOSE 1	MINIMUM INTERVAL BETWEEN DOSES			
		DOSE 1 TO DOSE 2	DOSE 2 TO DOSE 3	DOSE 3 TO DOSE 4	DOSE 4 TO 5
Diphtheria/Tetanus/Pertussis	6 Weeks	4 Weeks	4 Weeks	6 Months	6 Months
Inactivated Poliovirus	6 Weeks	4 Weeks	4 Weeks	4 Weeks	
Hepatitis B	Birth	4 Weeks	8 Weeks (and 16 weeks after first dose)		
Measles/Mumps/Rubella	12 Months	4 Weeks			
Varicella	12 Months				
<i>Haemophilus influenzae</i> type b	6 Weeks	4 Weeks if first dose given at age <12 months 8 Weeks (as final dose) if first dose given at age 12-14 months No further doses needed if first dose given at age ≥15 months	4 Weeks if current age <12 months 8 Weeks (as final dose) if current age ≥12 months and second dose given at age <15 months No further doses needed if previous dose given at age ≥15 months	8 Weeks (as final dose) This dose only necessary for children aged 12 months-5 years who received 3 doses before age 12 months.	
Pneumococcal Conjugate	6 Weeks	4 Weeks if first dose given at age <12 months and current age <24 months 8 Weeks (as final dose) if first dose given at age ≥12 months or current age 24-59 months No further doses needed for healthy children if first dose given at age ≥24 months	4 Weeks if current age <12 months 8 Weeks (as final dose) if current age ≥12 months No further doses needed for healthy children if previous dose given at age ≥24 months	8 Weeks (as final dose) This dose only necessary for children aged 12 months-5 years who received 3 doses before age 12 months.	

CATCH-UP SCHEDULE FOR CHILDREN AGED 7 YEARS THROUGH 18 YEARS

VACCINE	MINIMUM AGE FOR DOSE 1	MINIMUM INTERVAL BETWEEN DOSES	DOSE 3 TO BOOSTER DOSE
Diphtheria/Tetanus		4 Weeks	6 Months if first dose given at age <12 months and current age <11 years 5 Years if first dose given at age ≥12 months and third dose given at age <7 years and current age ≥11 years 10 Years if third dose given at age ≥7 years
Inactivated Poliovirus		4 Weeks	IPV
Hepatitis B		4 Weeks	8 Weeks (and 16 weeks after first dose)
Measles/Mumps/Rubella		4 Weeks	
Varicella		4 Weeks	

Source: Centers for Disease Control (CDC)

Exhibit 4EC 2

PROPORTION OF COMPLETELY IMMUNIZED CHILDREN/YOUTH*
NASSAU COUNTY
2000-2004

SCHOOL YEAR					
2000-2001		2001-2002		2003-2004	
Age	%	Age	%	Age	%
Pre- Kindergarten	94	Pre- Kindergarten	95	Pre- Kindergarten	92
All Pre-Kindergartens	94	All Pre-Kindergartens	94	All Pre-Kindergartens	92
Headstarts	76	Headstarts	92	Headstarts	90
Kindergarten	97	Kindergarten	97	Kindergarten	97
Grade 1 -2	94	Grade 1-3	95	Grade 1	96
Grades 3-10	95	Grades 4-11	95	Grades 2-5	95
Grades 11-12	96	Grade 12	95	Grade 6	96
				Grade 7	92
				Grade 8	91
				Grades 9-10	93
				Grades 11-12	94
% of Total	95	% of Total	95	% of Total	94

*Pre-Kindergarten through Grade 12

Source: NYS School Immunization Survey

Exhibit 4EC 3

**REPORTED CASES OF VACCINE-PREVENTABLE COMMUNICABLE DISEASES
NASSAU COUNTY
1985-2004**

YEAR	COMMUNICABLE DISEASES*				
	Haemophilus Influenza	Measles	Mumps	Pertussis**	Rubella
1985	10	4	17	6	6
1986	12	6	17	19	5
1987	7	1	18	14	3
1988	9	1	19	4	0
1989	8	26	10	17	3
1990	7	43	22	19	0
1991	2	23	4	9	0
1992	4	5	8	10	0
1993	7	3	1	16	11
1994	20	9	0	11	0
1995	7	0	2	9	0
1996	0	5	2	13	1
1997	8	2	2	11	2
1998	8	0	0	4	5
1999	8	2	1	7	17
2000	12	0	3	12	0
2001	8	2	2	4	0
2002	12	0	1	7	1
2003	29	1	0	69	0
2004	15	0	0	51	0

*There have been no reported cases of polio during this time period.

**Probable pertussis (whooping cough) cases became reportable as of 2003.

Source: Nassau County Department of Health

Exhibit 4EC 4

**ASTHMA HOSPITAL DISCHARGES (Age 0-4) IN NASSAU COUNTY
BY SELECTED COMMUNITIES
2000-2002**

2010 Objective = 25.0*

Zip Code	Community	Discharges 2000-2002	Population 2001	Avg. Yearly Discharge Rate*
11550	Hempstead	184	3,525	174.0
11575	Roosevelt	52	1,295	133.8
11096	Inwood	17	434	130.6
11553	Uniondale	52	1,343	129.1
11590	Westbury	73	2,698	90.2
11520	Freeport	76	2,925	86.6
11003	Elmont	18	1,616	81.1
Total		472	13,836	113.7
Rest of County		733	69,849	35.0
Nassau County		1,205	83,685	48.0

*Rate per 10,000

Source: New York State Department of Health

Exhibit 4EC 5

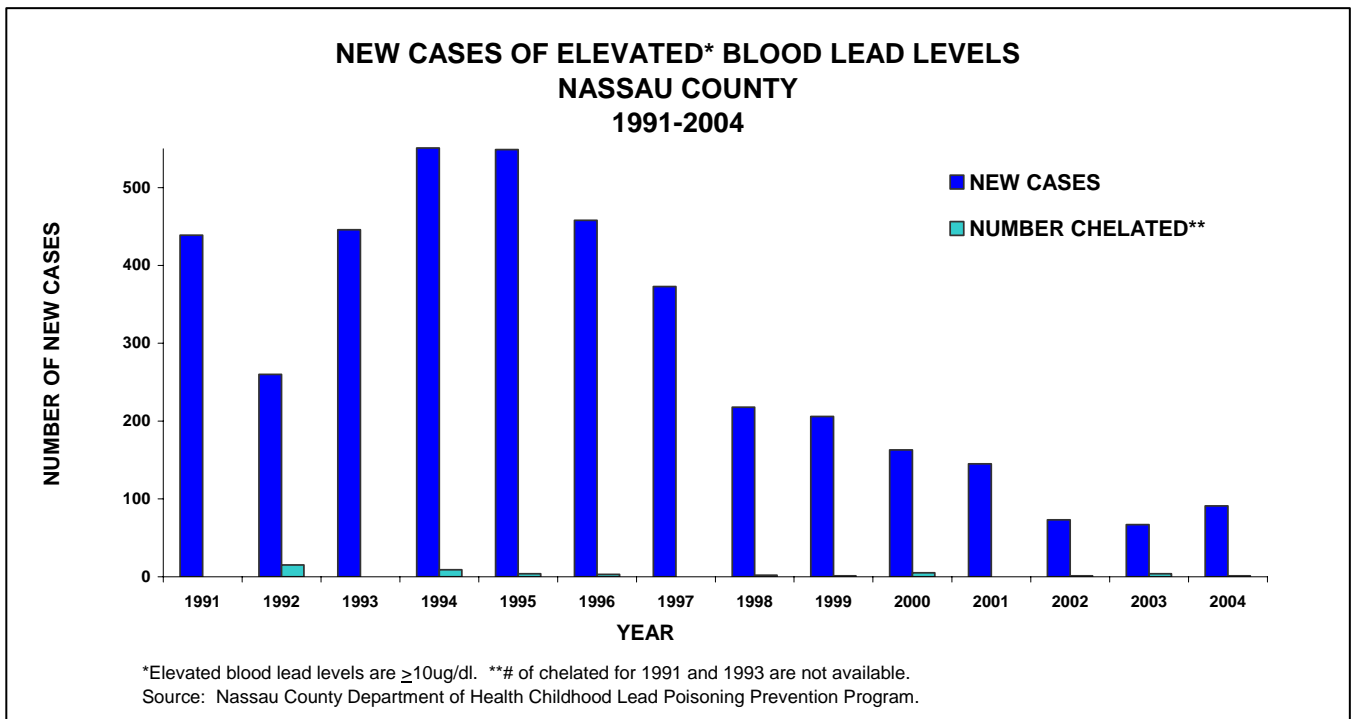


Exhibit 4EC 6

**NEW CASES AND RATES OF BLOOD LEAD LEVELS >10ug/dl
BY SELECTED COMMUNITIES IN NASSAU COUNTY
1997-2001**

NUMBER OF CASES

YEAR	SELECTED COMMUNITIES							TOTAL		
	11520 Freeport	11550 Hempstead	11096 Inwood	11561 Long Beach	11590 Westbury	11575 Roosevelt	11553 Uniondale	Selected Communities	Rest of County	Nassau County
1997	23	38	5	7	16	6	7	102	122	225
1998	12	34	6	5	7	9	3	76	84	166
1999	14	22	6	2	8	8	2	62	78	144
2000	16	24	3	3	14	17	5	82	84	184
2001	16	19	0	0	13	3	1	52	92	155

RATE/PER 100 CHILDREN SCREENED*

YEAR	SELECTED COMMUNITIES							TOTAL		
	11520 Freeport	11550 Hempstead	11096 Inwood	11561 Long Beach	11590 Westbury	11575 Roosevelt	11553 Uniondale	Selected Communities	Rest of County	Nassau County
1997	1.5	1.6	1.7	0.8	1.1	0.9	1.0	1.3	0.6	0.8
1998	0.8	1.4	2.0	0.6	0.5	1.4	0.4	1.0	0.4	0.6
1999	0.9	1.0	2.4	0.3	0.6	1.4	0.3	0.8	0.4	0.5
2000	1.3	1.3	1.5	0.5	1.2	3.5	1.0	1.4	0.6	0.7
2001	1.3	1.1	0.0	0.0	1.0	0.7	0.2	0.9	0.7	0.5

*Children aged 0-<6 years old.

Source: New York State Department of Health

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Exhibit 5AD 1

**ANNUAL NUMBER OF CASES OF SELECTED REPORTABLE COMMUNICABLE DISEASES
NASSAU COUNTY
1990-2003**

DISEASE	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
AIDS *	230	242	289	313	262	265	355	289	209	157	119	249	119	62
CAMPYLOBACTERIOSIS	154	168	273	261	279	267	193	188	196	203	192	163	177	186
CHLAMYDIA												1,219	1,353	1,678
CRYPTOSPORIDIOSIS						16	9	15	14	23	19	6	10	4
E. COLI 0157:H7 INFECTION						7	12	2	11	11	16	15	9	6
ENCEPHALITIS, OTHER						6	8	6	6	6	19	30	37	13
GIARDIASIS	93	113	184	168	189	198	221	201	178	201	192	132	146	135
GONOCOCCAL INFECTION	1,183	1,245	840	770	623	641	341	272	364	384	423	467	500	440
HAEMOPHILUS INFLUENZA	7	2	4	7	20	8	3	10	8	9	13	8	13	27
HEPATITIS A	51	83	62	88	56	38	52	58	59	35	43	60	46	31
HEPATITIS B	50	55	54	35	33	24	20	28	19	15	23	21	17	14
HEPATITIS C (Non A/Non B)	9	7	6	8	0	5	0	3	1	1	1	3	5	1
LEGIONELLOSIS						5	5	4	5	3	11	6	4	12
LYME DISEASE	188	95	106	133	181	176	164	121	110	107	86	48	82	75
MALARIA				15	12	16	24	10	17	11	19	19	11	11
MEASLES	43	25	5	3	9	0	5	2	0	2	0	2	0	1
MENINGITIS, ASEPTIC	59	211	62	70	65	82	86	69	100	24			172	162
MENINGOCOCCAL INFECTION	11	8	8	16	9	9	8	9	7	7	9	7	4	7
MUMPS	20	14	8	1	0	2	2	2	0	1	3	2	0	0
PERTUSSIS	17	8	10	16	11	12	13	11	4	8	11	4	10	71
RUBELLA	0	0	0	11	0	0	1	2	5	17	0	0	1	0
SALMONELLOSIS	225	306	228	232	297	299	284	291	215	217	186	189	230	174
SHIGELLOSIS	32	46	41	93	68	107	73	66	96	79	262	241	64	78
STREP GROUP A, INVASIVE						3	25	30	27	30	32	40	30	39
STREP GROUP B INVASIVE												39	57	82
STREP PNEUMONIA						0	18	19	33	18	21	140	133	117
SYPHILIS: EARLY	172	81	41	132	62	32	21	17	8	10	4	6	15	16
SYPHILIS: LATE				270	185	199	175	197	141	109	0	0	0	94
TUBERCULOSIS	100	86	94	122	100	95	82	84	90	76	70	94	65	56
TYPHOID FEVER				4	2	2	4	7	6	3	4	4	3	3
WEST NILE VIRUS										6	0	4	11	17
YERSINIOSIS	13	13	8	16	12	13	7	14	7	8	9	10	6	4

* Does not include prison inmates for all years. 2000 through 2003 are provisional data.

Source: New York State Department of Health

Exhibit 5AD 2

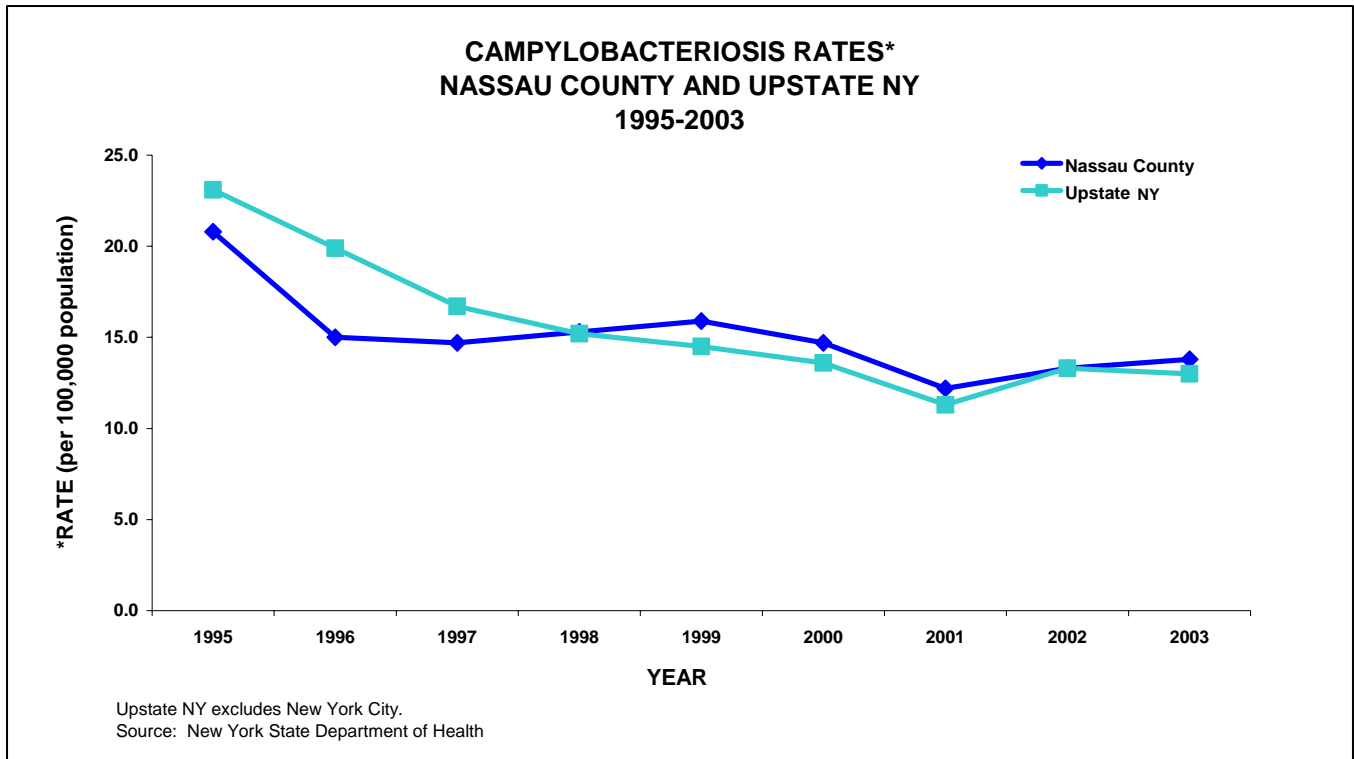


Exhibit 5AD 3

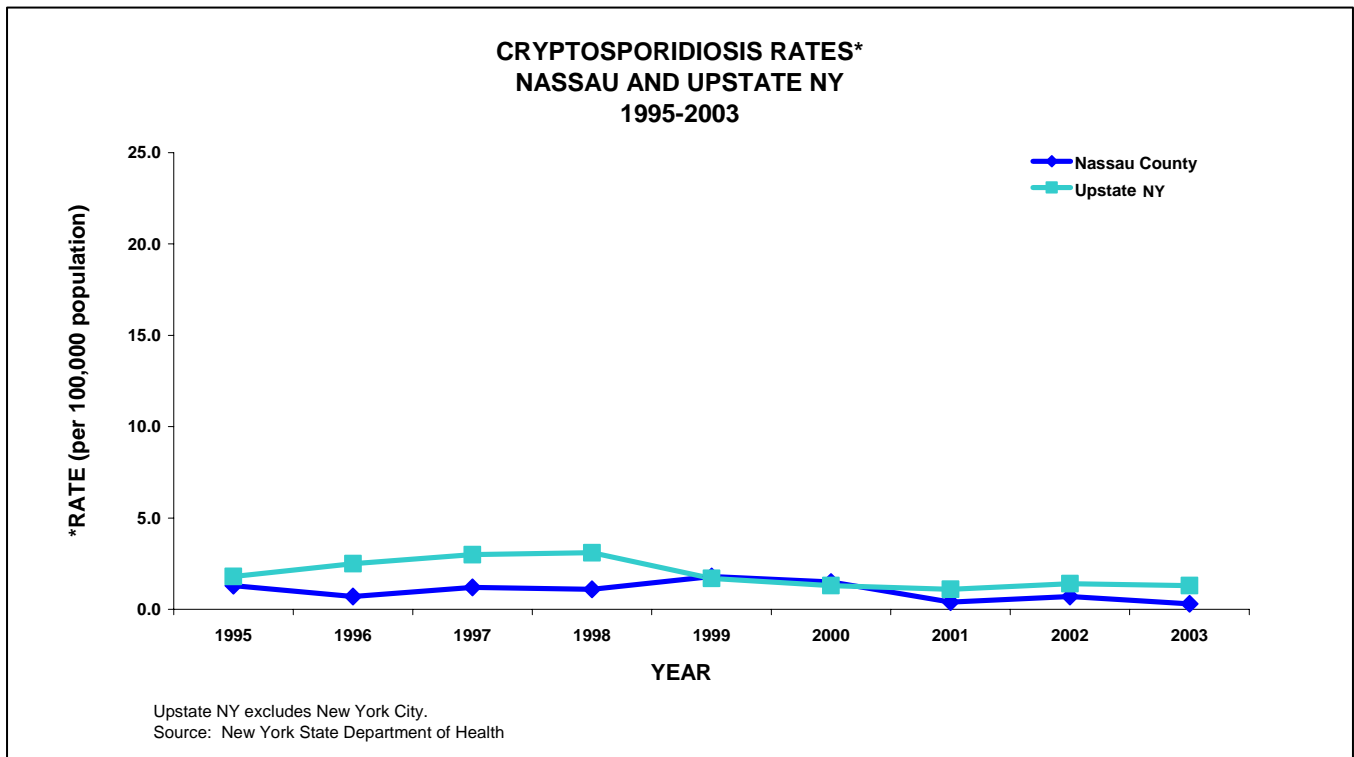
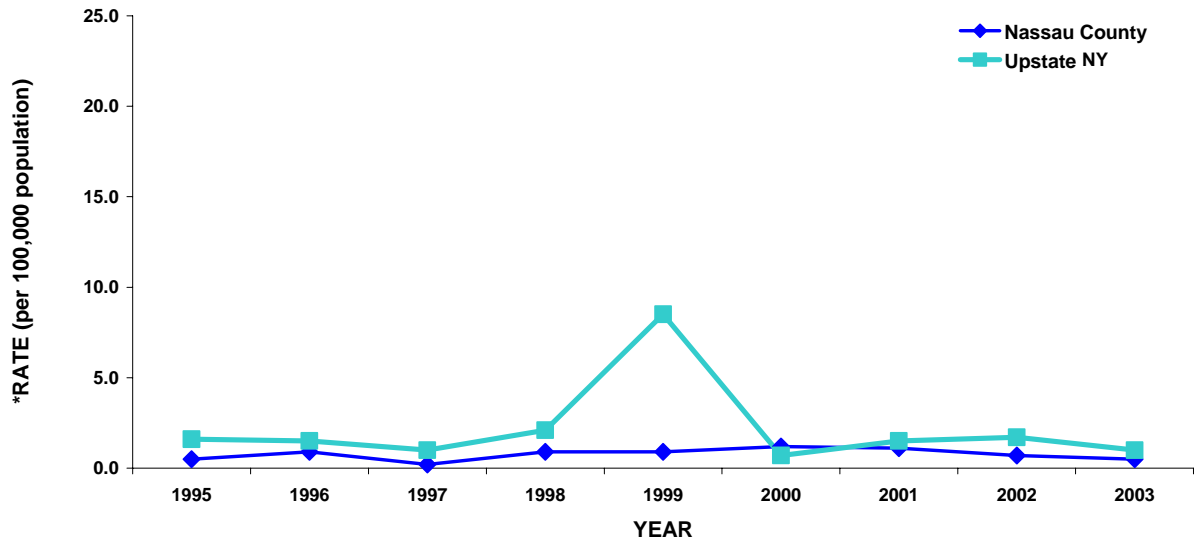


Exhibit 5AD 4

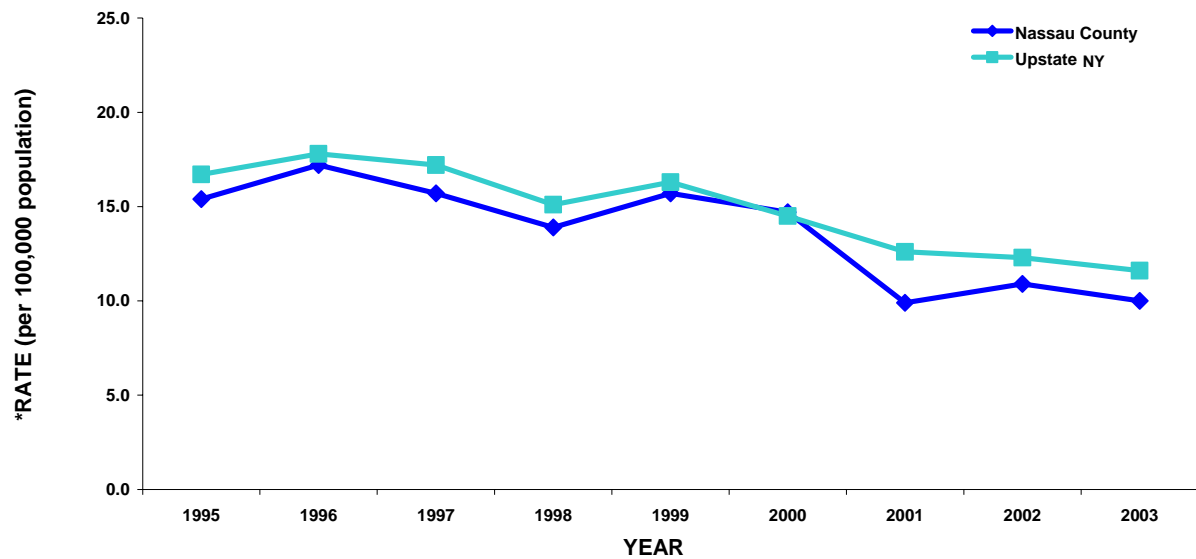
E COLI 0157:H7 RATES*
NASSAU COUNTY AND UPSTATE NY
1995-2003



Upstate NY excludes New York City.
 Source: New York State Department of Health

Exhibit 5AD 5

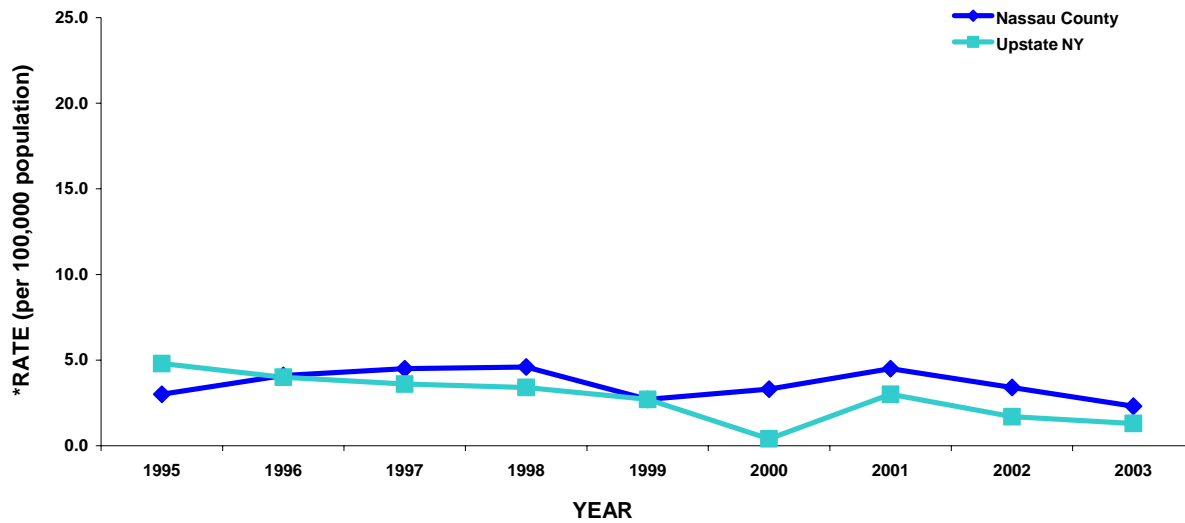
GIARDIASIS RATES*
NASSAU COUNTY AND UPSTATE NY
1995-2003



Upstate NY excludes New York City.
 Source: New York State Department of Health

Exhibit 5AD 6

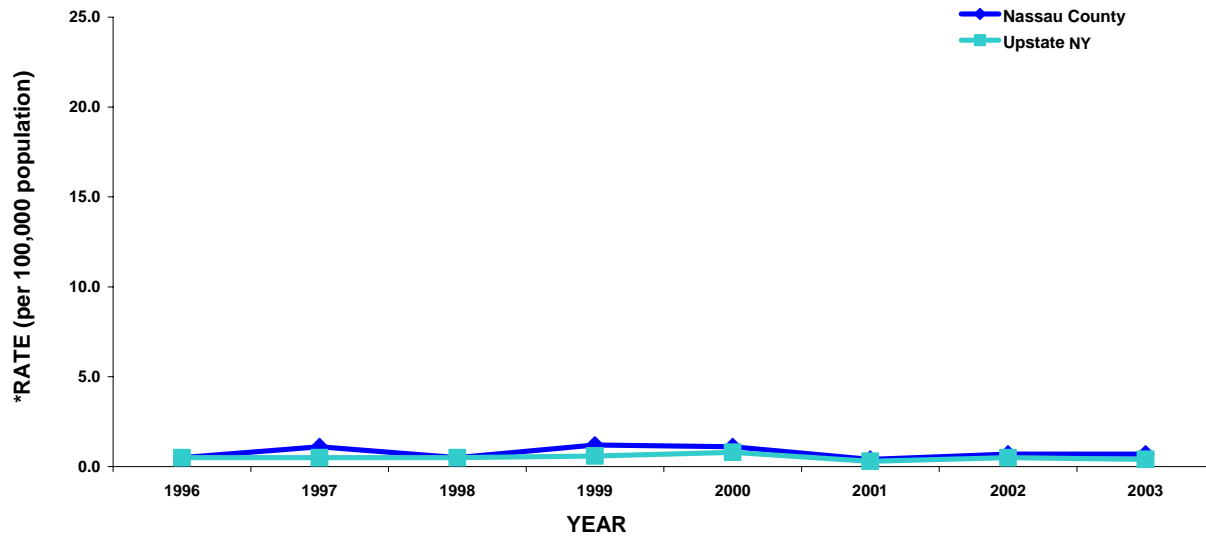
HEPATITIS A RATES*
NASSAU COUNTY AND UPSTATE NY
1995-2003



Upstate NY excludes New York City.
Source: New York State Department of Health

Exhibit 5AD 7

LISTERIOSIS RATES*
NASSAU COUNTY AND UPSTATE NY
1996-2003



Upstate NY excludes New York City.
Source: New York State Department of Health

Exhibit 5AD 8

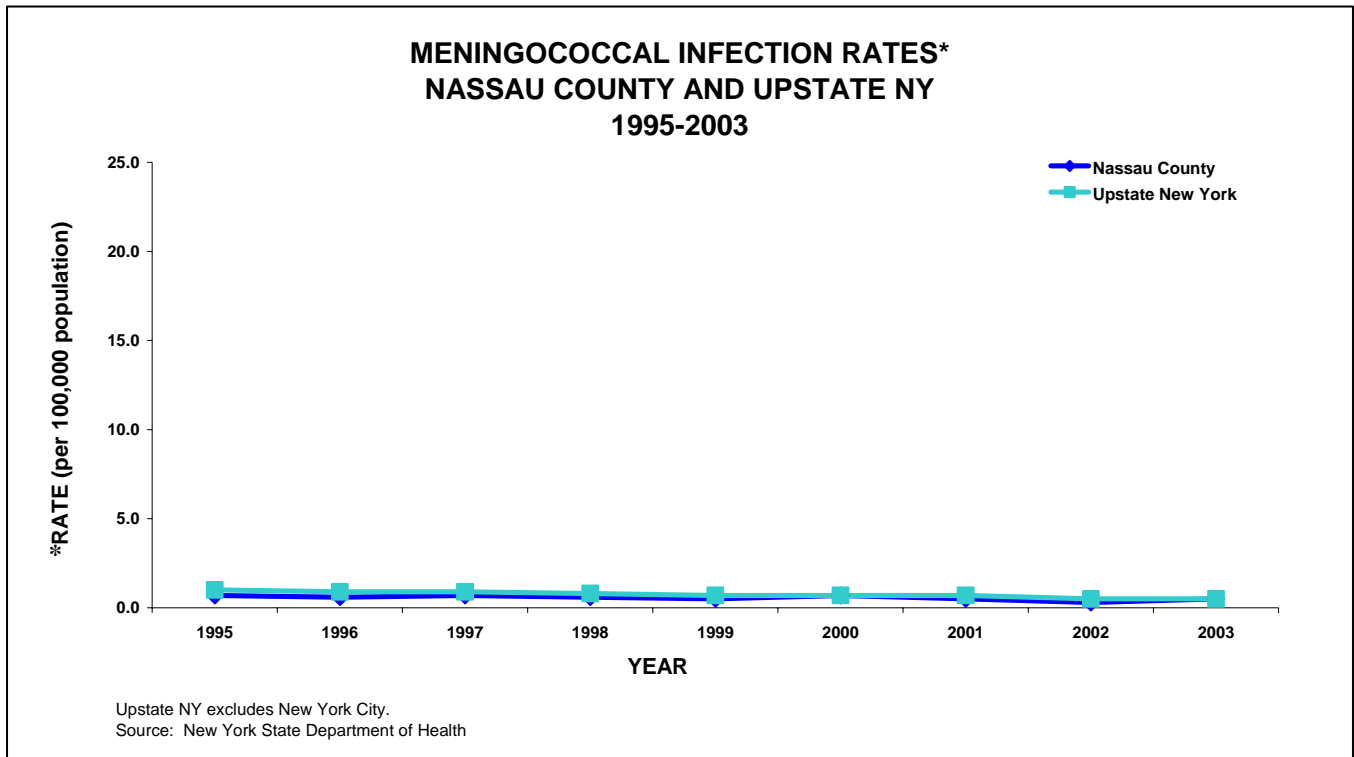


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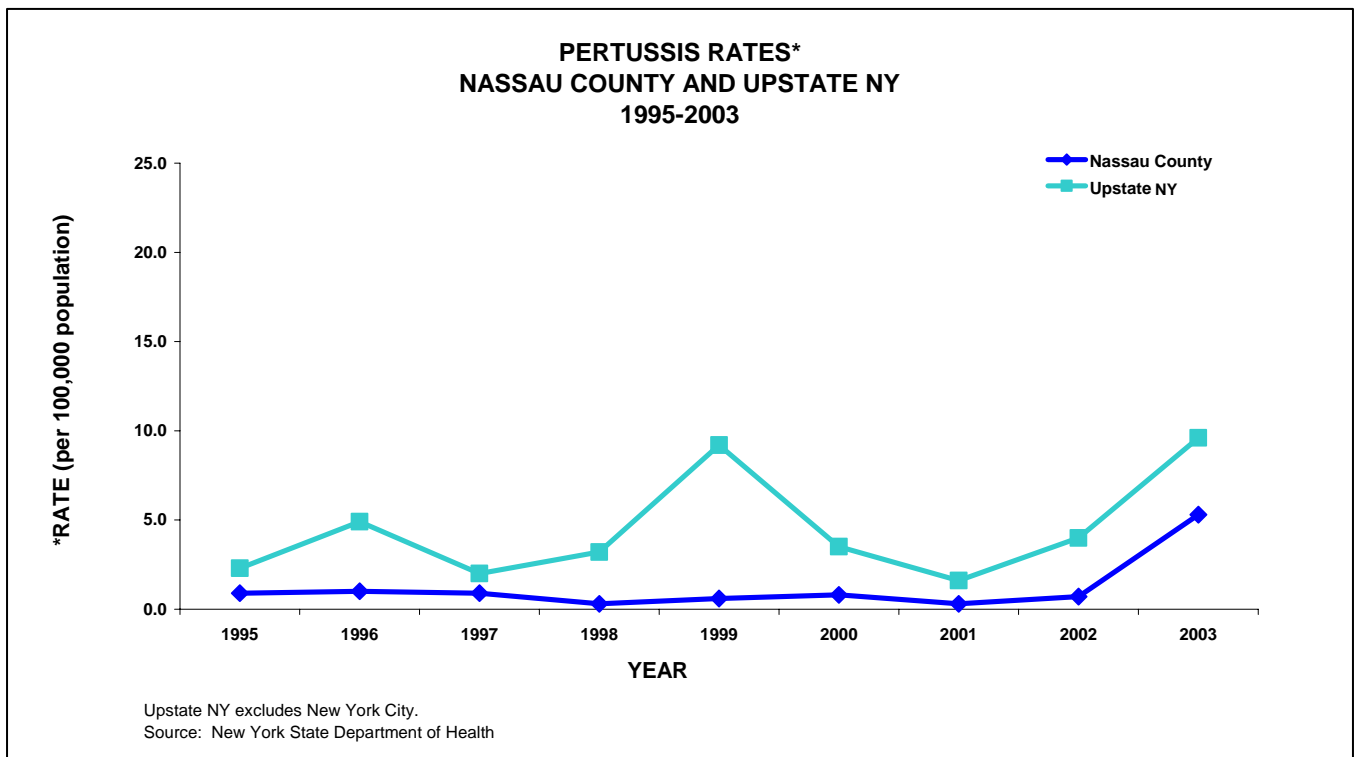


Exhibit 5AD 10

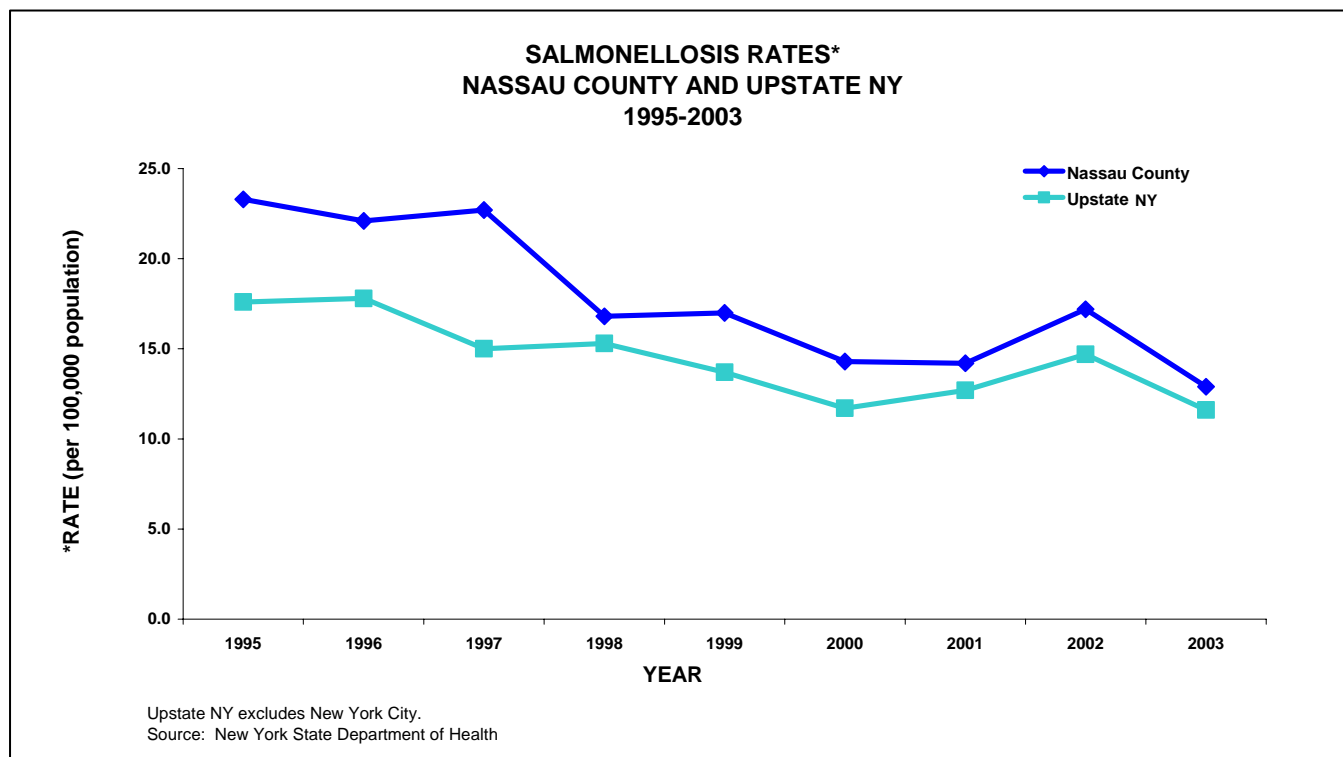


Exhibit 5AD 11

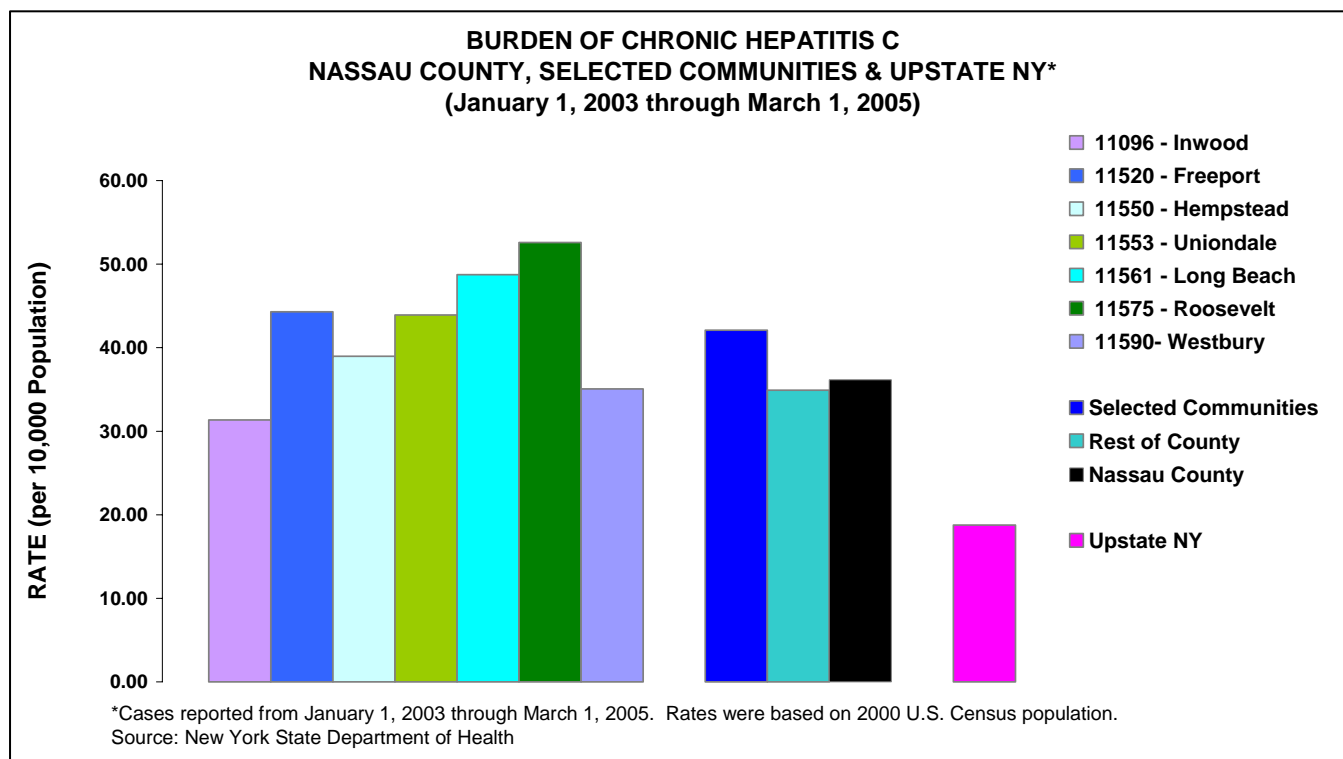


Exhibit 5AD 12

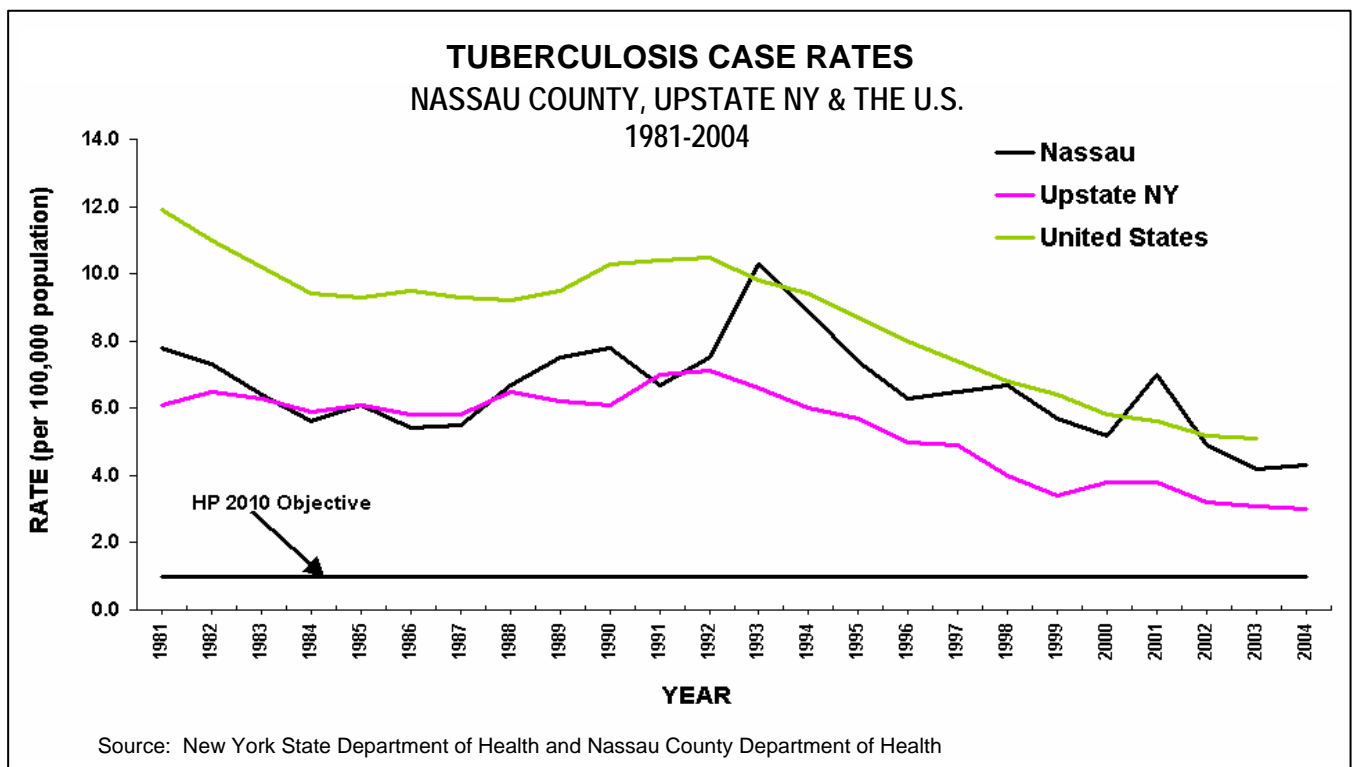
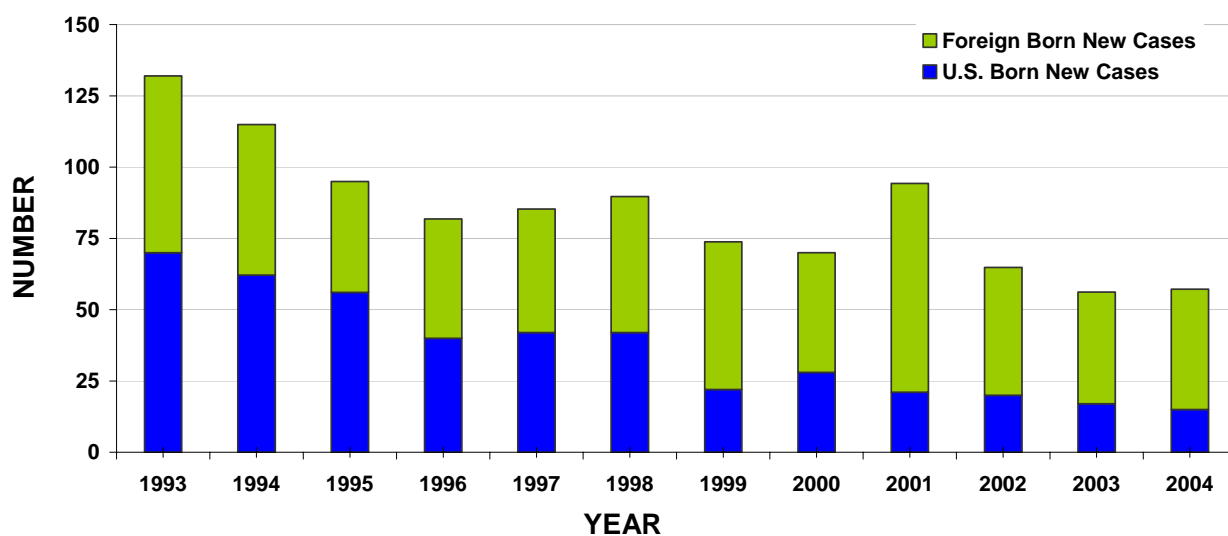


Exhibit 5AD 13

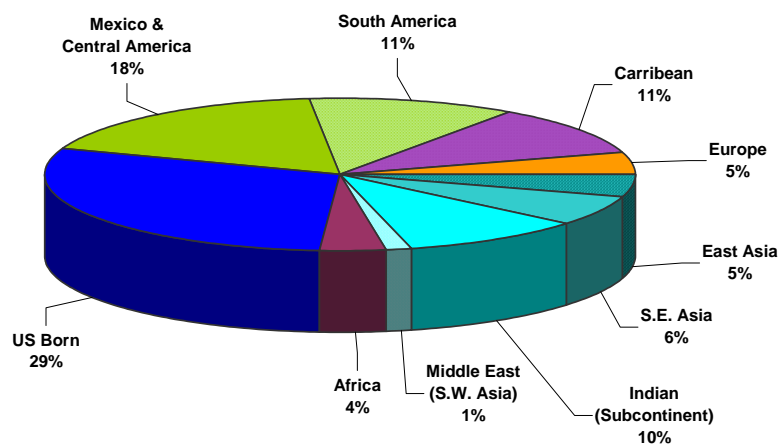
REPORTED CASES OF TUBERCULOSIS NASSAU COUNTY 1993-2004



Source: Nassau County Department of Health, Tuberculosis Control Bureau

Exhibit 5AD 14

TUBERCULOSIS CASES BY REGION OF ORIGIN 2000-2004



Source: Nassau County Department of Health, Tuberculosis Control Bureau

Exhibit 5AD 15

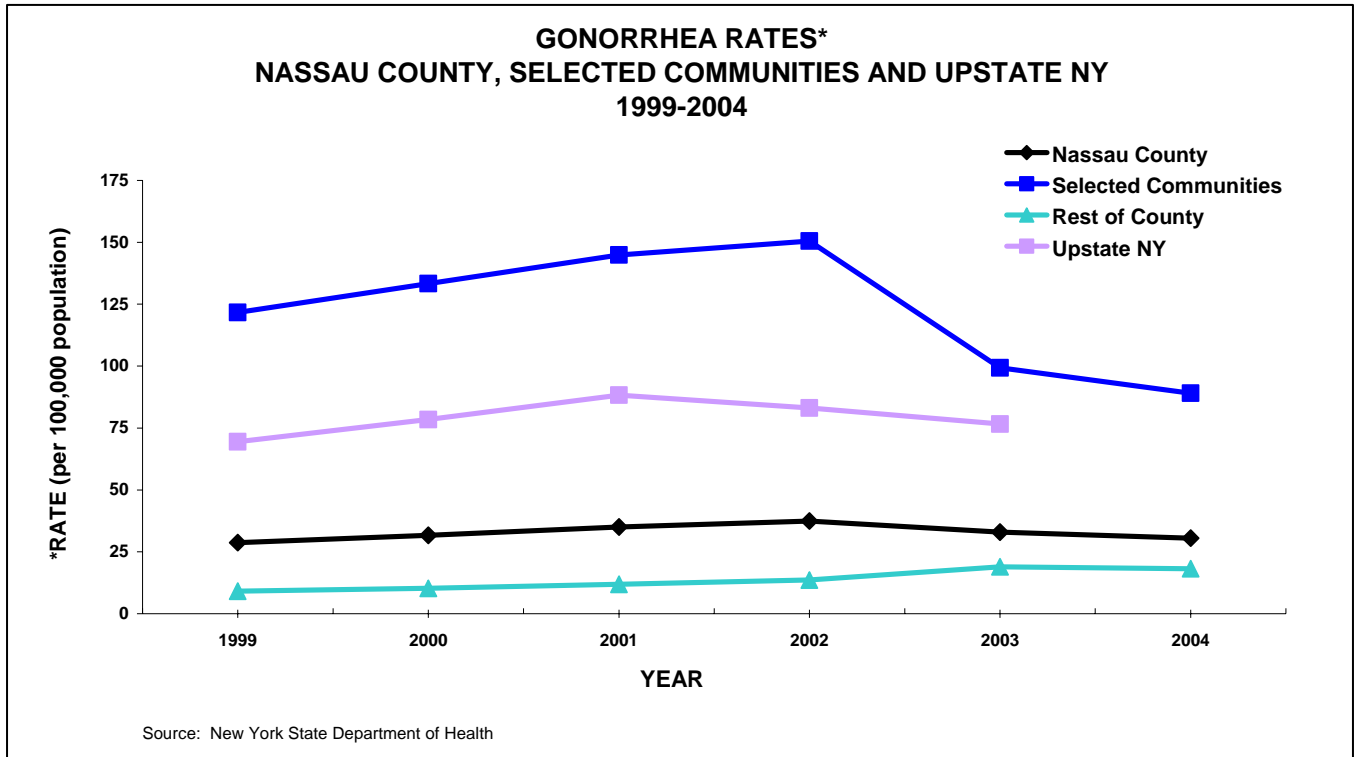


Exhibit 5AD 16

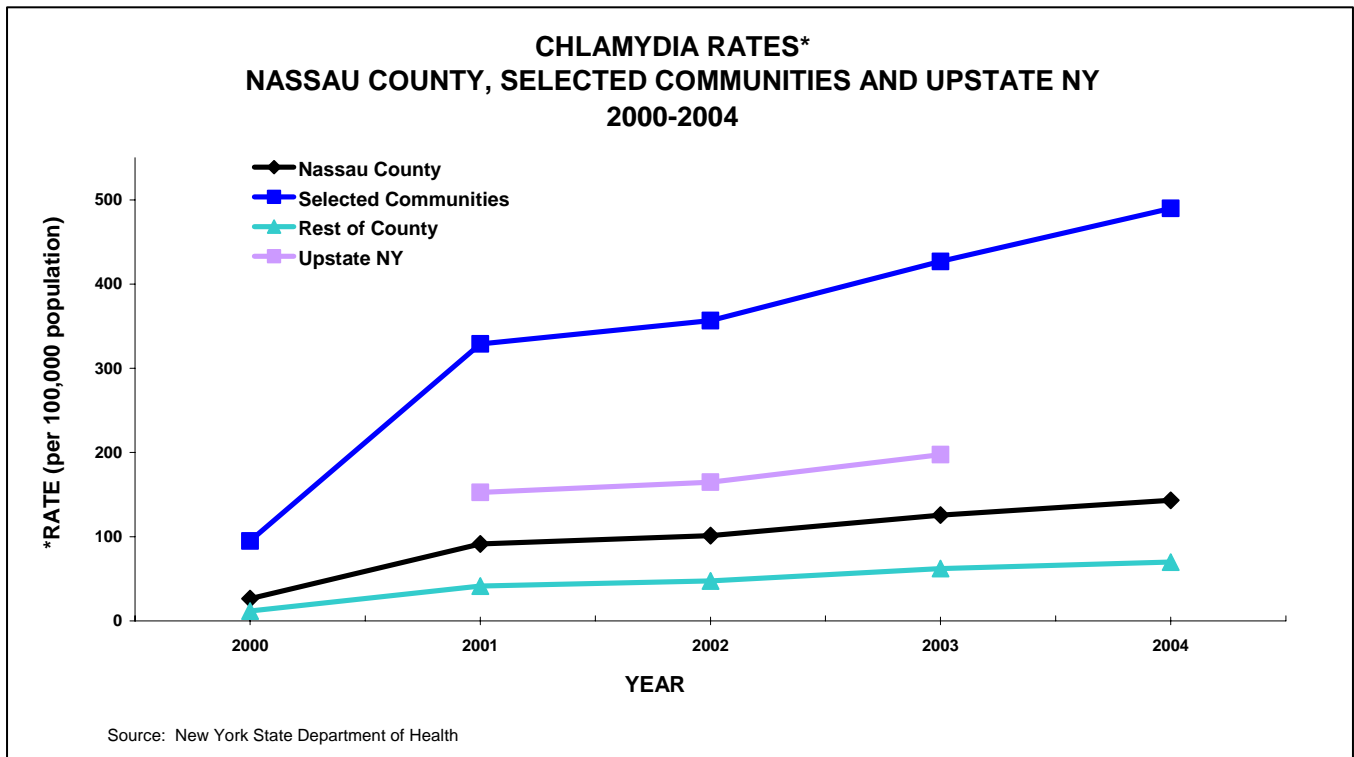


Exhibit 5AD 17

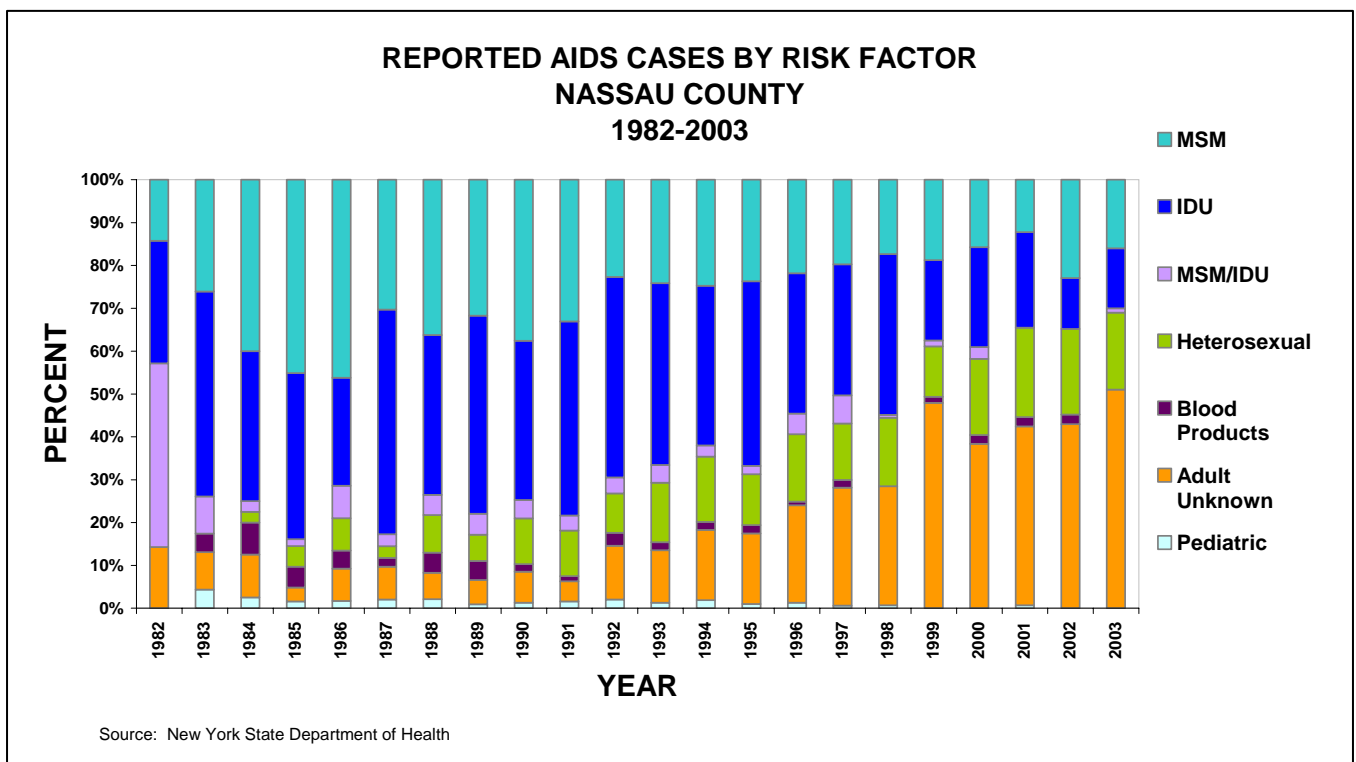


Exhibit 5AD 18

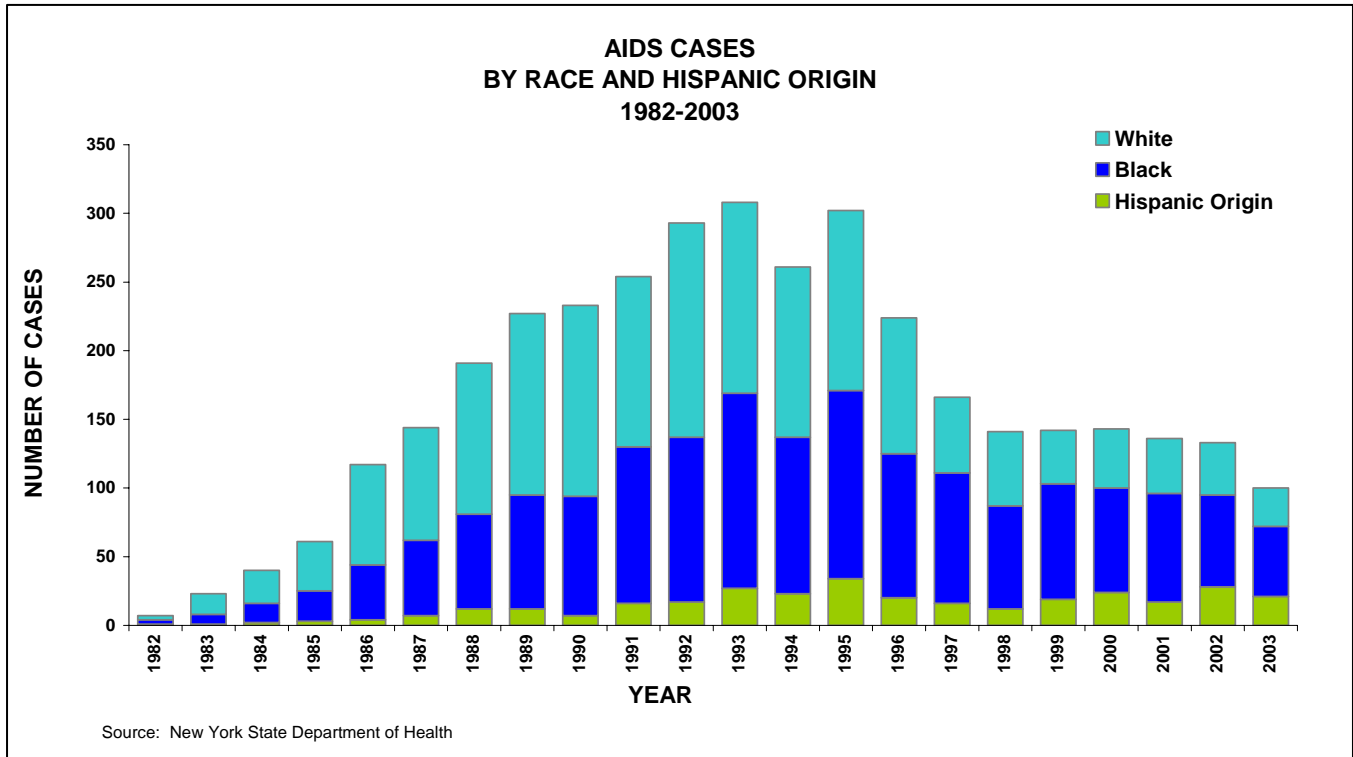
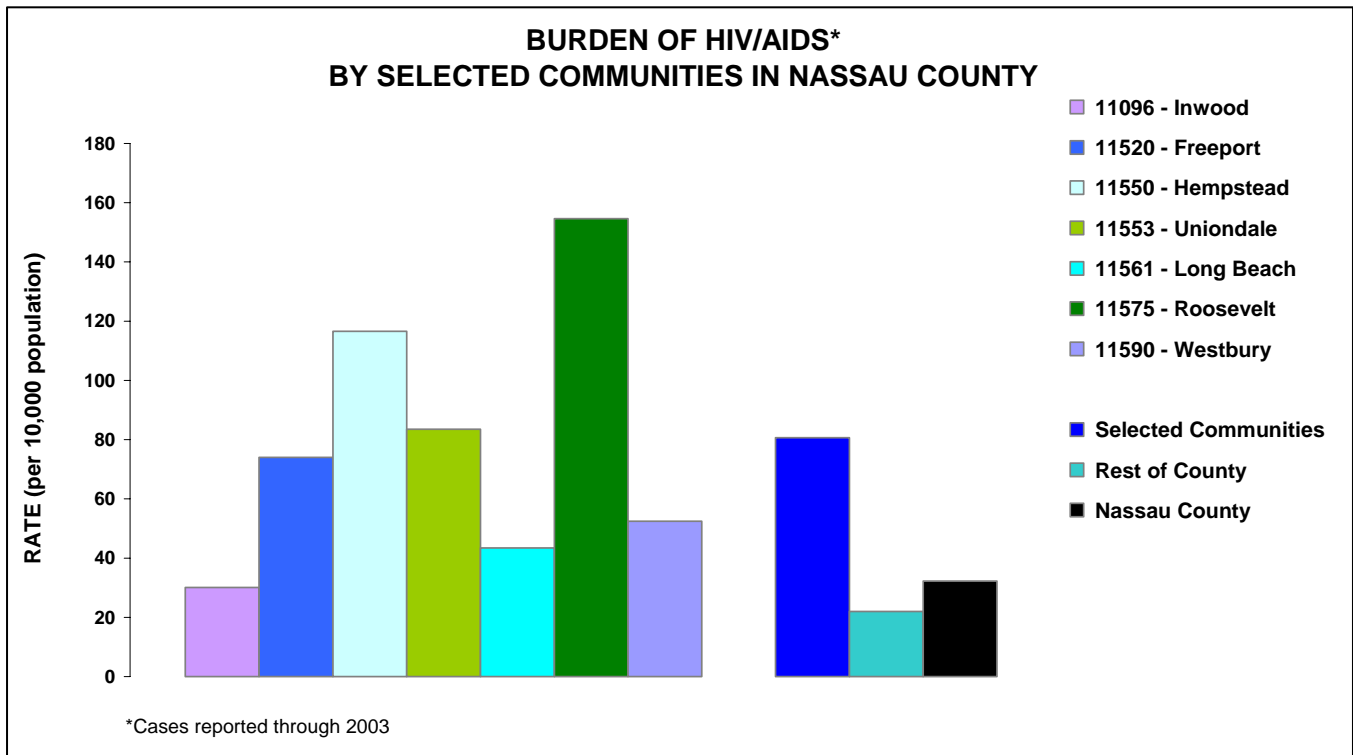


Exhibit 5AD 19



**Hospitalizations & Deaths Due to
Unintentional Injuries
Summary Statistics
NASSAU COUNTY**

Characteristics	Hospitalizations 2001-2003		Deaths 1999-2001	
	Mean Annual Frequency	Rate*	Mean Annual Frequency	Rate*
Total	9,182	682.8	318	23.9
Age Group				
0-4	242	291.7	4	4.2**
5-9	163	177.9	*	*
10-14	235	245.3	3	3.2**
15-19	327	384.5	15	18.1
20-24	315	425.7	16	23.5
25-44	1,363	366.7	83	21.6
45-64	1,544	452.0	62	19.4
65+	4,993	2,468.6	133	66.1
Gender				
Male	4,182	644.5	203	31.6
Female	5,000	718.4	115	16.7
% Traumatic Brain Injury	14.1		29.3	
Mean Charge per Hospitalization	\$24,164		N/A	
Total Hospitalization Charges	\$665.6 Million		N/A	
Average Length of Hospital Stay (days)	7.1		N/A	

*Rate = Per 100,000 population. *Data based on frequencies less than six not reported.

**Caution: Rates calculated using frequencies of less than 20 are unstable

Source: NYSDOH, Bureau of Injury Prevention

**Hospitalizations
Due to Unintentional Injury
Leading Causes by Age**

**NASSAU COUNTY
2001 - 2003**

Ages 0-4		Ages 5-9	
Cause	μ	Cause	μ
Fall	109	Fall	78
Poisoning	30	Motor Vehicle Traffic	24
Hot Object/Scald	18	Struck By, Against	10
Motor Vehicle Traffic	16	Pedal Cyclist, Non-Traffic	10
Struck By, Against	9	Natural/Environmental	9
Ages 10-14		Ages 15-19	
Cause	μ	Cause	μ
Fall	90	Motor Vehicle Traffic	135
Motor Vehicle Traffic	50	Fall	67
Struck By, Against	25	Struck By, Against	29
Pedal Cyclist, Non-Traffic	18	Poisoning	21
Poisoning	9	Overexertion	15
Ages 20-24		Ages 25-44	
Cause	μ	Cause	μ
Motor Vehicle Traffic	158	Motor Vehicle Traffic	430
Fall	54	Fall	386
Poisoning	19	Poisoning	109
Struck By, Against	16	Cut/Pierce	61
Cut/Pierce	13	Overexertion	57
Ages 45-64		Ages 65+	
Cause	μ	Cause	μ
Fall	782	Fall	4,052
Motor Vehicle Traffic	287	Motor Vehicle Traffic	299
Poisoning	79	Poisoning	69
Overexertion	52	Struck By, Against	53
Cut/Pierce	40	Natural/Environmental	50

**Deaths
Due to Unintentional Injury
Leading Causes by Age**

**NASSAU COUNTY
1999 - 2001**

Ages 0-4		Ages 5-9	
Cause	μ	Cause	μ
*	*	*	*
Ages 10-14		Ages 15-19	
Cause	μ	Cause	μ
Motor Vehicle Traffic	3	Motor Vehicle Traffic	10
*	*	*	*
Ages 20-24		Ages 25-44	
Cause	μ	Cause	μ
Motor Vehicle Traffic	10	Poisoning	33
Poisoning	4	Motor Vehicle Traffic	30
*	*	Transport, Non-Traffic	4
		Fall	4
		Fire/Flame	2
Ages 45-64		Ages 65+	
Cause	μ	Cause	μ
Motor Vehicle Traffic	22	Fall	68
Poisoning	16	Motor Vehicle Traffic	38
Fall	8	Fire/Flame	8
Transport, Non-Traffic	6	Suffocation	4
Fire/Flame	2	Poisoning	2

μ = Mean Annual Frequency. *Data based on frequencies less than six not reported

Source: NYSDOH, Bureau of Injury Prevention

μ = Mean Annual Frequency. *Data based on frequencies less than six not reported

Source: NYSDOH, Bureau of Injury Prevention

Exhibit 5AD 21

**Hospitalizations Due to Injury
Motor Vehicle Traffic Subcategories
Leading Causes by Age**

**NASSAU COUNTY
2001 - 2003**

Ages 0-4		Ages 5-9	
Cause	μ	Cause	μ
Occupant	9	Pedestrian	10
Pedestrian	6	Occupant	10
*		Pedal Cyclist	3
*		*	
Ages 10-14		Ages 15-19	
Cause	μ	Cause	μ
Pedestrian	21	Occupant	89
Occupant	14	Pedestrian	25
Pedal Cyclist	11	Pedal Cyclist	7
Motorcyclist	3	Motorcyclist	7
Ages 20-24		Ages 25-44	
Cause	μ	Cause	μ
Occupant	99	Occupant	265
Motorcyclist	26	Pedestrian	65
Pedestrian	19	Motorcyclist	54
Pedal Cyclist	6	Pedal Cyclist	19
Ages 45-64		Ages 65+	
Cause	μ	Cause	μ
Occupant	175	Occupant	221
Pedestrian	61	Pedestrian	57
Motorcyclist	23	Pedal Cyclist	3
Pedal Cyclist	9	Motorcyclist	2

μ = Mean Annual Frequency. *Data based on frequencies less than six not reported
Source: NYSDOH, Bureau of Injury Prevention

**Deaths Due to Injury
Motor Vehicle Traffic Subcategories
Leading Causes by Age**

**NASSAU COUNTY
1999 - 2001**

Ages 0-4		Ages 5-9	
Cause	μ	Cause	μ
*	*	*	*
Ages 10-14		Ages 15-19	
Cause	μ	Cause	μ
Pedestrian	2	Occupant	7
*	*	*	*
Ages 20-24		Ages 25-44	
Cause	μ	Cause	μ
Occupant	5	Occupant	11
Motorcyclist	2	Pedestrian	8
*	*	Motorcyclist	5
		*	*
Ages 45-64		Ages 65+	
Cause	μ	Cause	μ
Occupant	10	Occupant	21
Pedestrian	9	Pedestrian	13
*	*	*	*

μ = Mean Annual Frequency. *Data based on frequencies less than six not reported
Source: NYSDOH, Bureau of Injury Prevention

**Hospitalizations and Deaths Due to
Assault/Homicide Injuries
Summary Statistics
NASSAU COUNTY**

Characteristics	Hospitalizations 2001-2003		Deaths 1999-2001	
	Mean Annual Frequency	Rate*	Mean Annual Frequency	Rate*
Total	311	23.1	31	2.3
Age Group				
0-4	2	2.8**	*	*
5-9	*	*	*	*
10-14	8	8.0	*	*
15-19	55	64.3	4	4.4**
20-24	57	77.0	8	11.7
25-44	141	37.8	12	3.2
45-64	35	10.3	5	1.5**
65+	12	5.8	*	*
Gender				
Male	257	39.7	25	3.9
Female	54	7.7	6	0.9**
Percent Traumatic Brain Injury	25.5		30.9	
Mean Charge per Hospitalization	\$19,057		N/A	
Total Hospitalization Charges	\$17.8 Million		N/A	
Average Length of Hospital Stay (days)	5.3		N/A	

*Rate = Per 100,000 population. *Data based on frequencies less than six not reported.
**Caution: Rates calculated using frequencies of less than 20 are unstable
Source: NYSDOH, Bureau of Injury Prevention

**Hospitalizations and Deaths
Due to Self Inflicted/Suicide Injuries
Summary Statistics
NASSAU COUNTY**

Characteristics	Hospitalizations 2001-2003		Deaths 1999-2001	
	Mean Annual Frequency	Rate*	Mean Annual Frequency	Rate*
Total	536	39.8	72	5.4
Age Group				
0-4	*	*	*	*
5-9	*	*	*	*
10-14	22	23.3	*	*
15-19	87	101.9	3	3.6**
20-24	58	77.9	6	9.3**
25-44	213	57.3	25	6.4
45-64	116	34.0	21	6.4
65+	39	19.4	17	8.3
Gender				
Male	222	34.3	54	8.4
Female	313	45.0	18	2.6
Percent Traumatic Brain Injury	0.6		33.5	
Mean Charge per Hospitalization	\$13,978		N/A	
Total Hospitalization Charges	\$22.5 Million		N/A	
Average Length of Hospital Stay (days)	5.3		N/A	

*Rate = Per 100,000 population. *Data based on frequencies less than six not reported.
**Caution: Rates calculated using frequencies of less than 20 are unstable
Source: NYSDOH, Bureau of Injury Prevention

Exhibit 5AD 22

**CANCER DEATHS AND RATES IN NASSAU COUNTY⁽¹⁾
1976-2001**

	1976-1981		1982-1986		1987-1991		1992-1996		1997-2001	
SITE OF CANCER	Avg. Yrly Deaths	Avg. Adj. Rate⁽²⁾	Avg. Yrly Deaths	Avg. Adj. Rate⁽²⁾	Avg. Yrly Deaths	Avg. Adj. Rate⁽²⁾	Avg. Yrly Deaths	Avg. Adj. Rate⁽²⁾	Avg. Yrly Deaths	Avg. Adj. Rate⁽²⁾
MALES										
ALL CANCER SITES	1,704	295.3	1,482	280.0	1,493	267.9	1,439	244.6	1,397	222.2
LUNG AND BRONCHUS	509	82.8	435	77.6	434	73.5	412	66.6	383	59.5
PROSTATE	142	32.8	142	33.6	166	35.5	165	32.7	156	27.0
COLORECTAL	252	46.8	222	44.4	209	40.0	186	32.1	156	25.0
PANCREAS	102	17.8	78	14.1	83	14.1	83	13.8	89	13.9
NON-HODGKIN'S LYMPHOMAS	53	7.7	54	9.9	66	11.1	67	11.2	68	10.7
LEUKEMIAS	68	10.7	57	10.6	59	10.0	60	10.5	66	10.4
BLADDER	65	13.4	56	12.1	46	9.4	50	9.3	48	8.4
STOMACH	68	12.3	65	12.5	53	9.6	55	9.6	44	7.0
ESOPHAGUS	47	7.6	37	6.4	37	5.9	40	6.2	42	6.5
BRAIN & NERVOUS SYSTEM	45	5.9	34	5.4	34	5.3	37	5.5	35	5.3
KIDNEY	50	7.8	37	6.3	35	5.9	33	5.3	34	5.3
LIVER	21	3.7	21	3.9	27	4.9	29	4.8	32	4.9
MELANOMA	28	3.9	26	4.5	29	4.9	28	4.7	30	4.6
MYELOMA	23	3.8	21	4.0	25	4.5	24	4.0	28	4.4
ORAL CAVITY & PHARYNX	45	6.9	37	6.0	34	5.8	27	4.2	20	3.0
FEMALES										
ALL CANCER SITES	1,644	195.3	1,493	196.4	1,499	189.5	1,514	182.7	1,447	165.4
LUNG AND BRONCHUS	225	25.7	248	31.9	310	38.6	328	39.0	343	39.0
BREAST	360	41.5	328	42.6	319	40.5	296	36.6	258	30.3
COLORECTAL	255	31.7	227	30.4	198	25.2	175	20.7	148	16.3
PANCREAS	92	11.1	80	10.5	82	10.3	89	10.5	94	10.5
OVARY	104	11.8	85	11.0	90	11.2	88	10.7	84	9.7
NON-HODGKIN'S LYMPHOMA	55	6.6	43	5.6	52	6.7	54	6.5	65	7.4
LEUKEMIAS	60	7.4	51	7.0	47	6.2	50	6.2	52	6.1
UTERUS, (corpus)	55	6.5	38	5.0	39	4.7	44	5.2	34	3.8
STOMACH	61	7.5	44	6.0	42	5.4	38	4.6	33	3.8
BRAIN & NERVOUS SYSTEM	34	3.9	31	4.1	26	3.2	30	3.7	25	3.0
MYELOMA	20	2.5	25	3.3	23	2.8	29	3.4	25	2.8
KIDNEY	25	3.0	21	2.7	24	2.9	20	2.4	23	2.6
CERVIX UTERI	26	3.0	18	2.4	18	2.5	21	2.7	19	2.4
LIVER	15	1.8	12	1.6	17	2.2	22	2.7	20	2.3
BLADDER	24	3.1	21	2.9	21	2.7	22	2.6	21	2.2

⁽¹⁾Top 15 Cancers, ranked by death rate 1997-2001

⁽²⁾Annual average rate per 100,000 sex and age-adjusted to the 2000 U.S. population

Source: New York State Department of Health, Cancer Registry, January, 2004

Exhibit 5AD 23

**CANCER CASES AND RATES IN NASSAU COUNTY⁽¹⁾
1976-2001**

	1976-1981		1982-1986		1987-1991		1992-1996		1997-2001	
SITE OF CANCER	Avg. Yrly Cases	Avg. Adj. Rate⁽²⁾	Avg. Yrly Cases	Avg. Adj. Rate⁽²⁾	Avg. Yrly Cases	Avg. Adj. Rate⁽²⁾	Avg. Yrly Cases	Avg. Adj. Rate⁽²⁾	Avg. Yrly Cases	Avg. Adj. Rate⁽²⁾
MALES										
ALL CANCER SITES	3,081	512.2	2,890	518.0	3,154	537.8	3,604	574.9	3,814	583.2
LUNG AND BRONCHUS	604	96.4	531	91.9	533	89.1	521	82.9	528	80.8
PROSTATE	418	84.0	438	90.0	642	115.9	1,047	161.1	1,148	171.7
COLORECTAL	535	92.0	498	91.3	508	88.4	473	78.0	477	74.3
PANCREAS	109	18.9	79	14.2	91	15.0	93	15.1	104	15.9
NON-HODGKIN'S LYMPHOMAS	113	16.4	121	20.1	134	21.6	158	25.8	163	25.4
LEUKEMIAS	100	15.7	93	16.1	88	15.0	97	16.4	104	16.4
BLADDER	247	42.6	247	44.8	255	43.6	260	43.1	301	47.0
STOMACH	92	16.2	91	16.5	86	14.9	94	15.8	91	14.4
ESOPHAGUS	53	8.4	41	6.8	35	5.4	47	7.4	46	7.1
BRAIN & NERVOUS SYSTEM	60	8.0	54	8.7	56	9.0	60	9.2	60	9.1
KIDNEY	85	12.6	91	14.6	96	15.3	117	18.4	125	18.7
LIVER	27	4.7	25	4.7	31	5.2	35	5.6	50	7.6
MELANOMA	80	11.5	91	15.2	87	14.0	92	14.5	120	18.2
MYELOMA	34	5.6	37	6.5	38	7.0	40	6.5	39	6.1
ORAL CAVITY & PHARYNX	118	16.9	93	15.3	90	14.5	84	13.3	83	12.5
FEMALES										
ALL CANCER SITES	3,361	395.2	3,120	413.2	3,420	440.8	3,636	452.5	3,849	461.7
LUNG AND BRONCHUS	294	33.2	325	42.0	403	50.1	453	54.4	498	57.4
BREAST	991	115.9	948	126.8	1,043	136.5	1,137	145.0	1,173	144.3
COLORECTAL	541	65.3	456	60.4	466	58.9	451	53.7	484	55.1
PANCREAS	95	11.5	87	11.5	98	12.4	94	11.1	115	12.9
OVARY	157	18.0	141	18.5	156	20.2	159	20.0	143	17.4
NON-HODGKIN'S LYMPHOMA	100	11.8	99	12.9	125	16.1	129	15.9	154	18.3
LEUKEMIAS	85	10.6	74	10.4	74	9.8	78	10.0	80	9.7
UTERUS, (corpus)	238	26.5	180	22.5	197	24.6	236	29.1	238	28.8
STOMACH	74	9.1	60	8.2	58	7.6	65	7.8	58	6.5
BRAIN & NERVOUS SYSTEM	46	5.5	45	6.0	43	5.7	50	6.5	46	6.0
MYELOMA	34	4.1	33	4.3	40	5.1	37	4.4	48	5.4
KIDNEY	46	5.5	49	6.3	61	7.6	66	8.2	79	9.5
CERVIX UTERI	72	8.5	51	7.2	65	9.3	64	8.7	64	8.3
LIVER	16	2.0	11	1.4	19	2.4	21	2.5	24	2.7
BLADDER	88	10.5	88	11.5	92	11.5	97	11.7	109	12.4

⁽¹⁾Top 15 Cancers, ranked by death rate 1997-2001 (1AD 20 - CANCER DEATHS & RATES IN NASSAU COUNTY, 1976-2001)

⁽²⁾Annual average rate per 100,000 sex and age-adjusted to the 2000 U.S. population

LEADING CAUSE OF DEATH BY AGE GROUP
NASSAU COUNTY
2002

Age Group	Cause of Death	# Deaths
0-14 Years		131
	Disorders related to premature birth	54
	Birth defects	15
	Unintentional Injury	10
	Cancer	7
	Symptoms related to unexplained death	5
	Homicide	5
15-24 Years		71
	Unintentional Injury	44
	Homicide	12
	Suicide	11
	Cancer	3
	Heart Disease	1
25-44 Years		299
	Cancer	75
	Heart Disease	68
	Unintentional Injury	64
	Suicide	23
	HIV/AIDS	22
	Homicide	19
44-64 Years		1,224
	Cancer	655
	Heart Disease	341
	Unintentional Injury	50
	CVD (Stroke)	45
	CLRD	38
	Cirrhosis	35
65+ Years		7,312
	Heart Disease	4,172
	Cancer	1,956
	CVD (Stroke)	431
	CLRD	416
	Diabetes	163
	Total Unintentional Injury (Falls = 62)	106

Source: New York State Department of Health Vital Statistics

APPENDIX 6 – LOCAL PUBLIC HEALTH SYSTEM

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2003 NASSAU COUNTY HOSPITAL PROFILES

Long Beach Medical Center

455 East Bay Drive, Long Beach, NY 11561

Long Beach Medical Center includes a 203-bed community teaching hospital, a 200-bed sub acute and skilled nursing facility, home-health agency and numerous outpatient services. The Family Care Center provides primary and specialty medical care for people with limited financial resources.

Admissions: 5,742, ER Visits: 14,852

Mercy Medical Center

1000 N. Village Avenue, Rockville Centre, NY 11570

Mercy Medical Center is sponsored by the Diocese of Rockville Centre and is one of five acute care hospitals within Catholic Health Services of Long Island. It is a 387-bed Level II Trauma Center serving the healthcare needs of residents of Nassau County and surrounding areas. It is best known for its maternal and child health services; oncology; physical medicine and rehabilitation; orthopedics; and behavioral health services. Mercy is a member of LIHN.

Admissions: 14,407, ER Visits: 40,652

Nassau University Medical Center

2201 Hempstead Turnpike, East Meadow, NY 11554

The Nassau University Medical Center, a Level I Regional Trauma Center, is part of the Nassau Health Care Corporation which also includes a skilled nursing facility and seven community health centers. The medical center is a 631-bed tertiary care teaching hospital, and it is affiliated with the Health Sciences Center of the State University of New York at Stony Brook and Lenox Hill Hospital.

Admissions: 22,091, ER Visits: 82,521

New Island Hospital

4295 Hempstead Turnpike, Bethpage, NY 11714

New Island Hospital is a 223-bed acute care facility that, since 1999, has existed as a joint venture between Winthrop South Nassau Health System and Catholic Health Services of Long Island. It offers inpatient, outpatient, and emergency services. Sleep medicine and hyperbarics/wound care are two of its more specialized services. New Island is currently a member of the Long Island Health Network (LIHN) – a group of hospitals that have voluntarily joined together to improve patient care through ensuring best practice standards in patient care, decreasing lengths of stay, and costs.

Admissions: 8,733, ER Visits: 35,442

North Shore/LIJ Health System

200 Community Drive, Great Neck, NY 11021

The North Shore/LIJ Health System serves Long Island, Queens and Staten Island and is headquartered in Great Neck, NY. The system is comprised of 17 hospitals, including three tertiary hospitals, a children's hospital and a psychiatric facility, hospice and home care services, a medical research institute and other health-related facilities. In Nassau County, the five hospitals that are part of the NSLIJ System are:

North Shore University Hospital – Manhasset (849 beds)

Glen Cove Hospital (281 beds)

Syosset Hospital (116 beds)

Franklin Hospital (305 beds)

Plainview Hospital (240 beds)

Admissions: 84,278, ER Visits: 144,000

(These are combined figures for the five North Shore/LIJ System hospitals located in Nassau County)

St. Francis Hospital

100 Port Washington Boulevard, Roslyn, NY 11576

St. Francis Hospital, The Heart Center is sponsored by the Diocese of Rockville Centre and is one of five acute care hospitals within Catholic Health Services of Long Island. It is New York's only specialty designated cardiac center and performs more cardiac procedures than any other hospital in the Northeast. It has a 279-bed capacity and is a member of the LIHN.

Admissions: 18,596, ER Visits: 18,117

South Nassau Communities Hospital

One Healthy Way, Oceanside, NY 11572

South Nassau Communities Hospital is a 429-bed acute care hospital, providing inpatient, ambulatory, home health, restorative, preventive, and emergency medical care. South Nassau is partner with Winthrop-University Hospital in the Winthrop South-Nassau University Health System and a member of the New York-Presbyterian Healthcare System.

Admissions: 15,047, ER Visits: 42,485

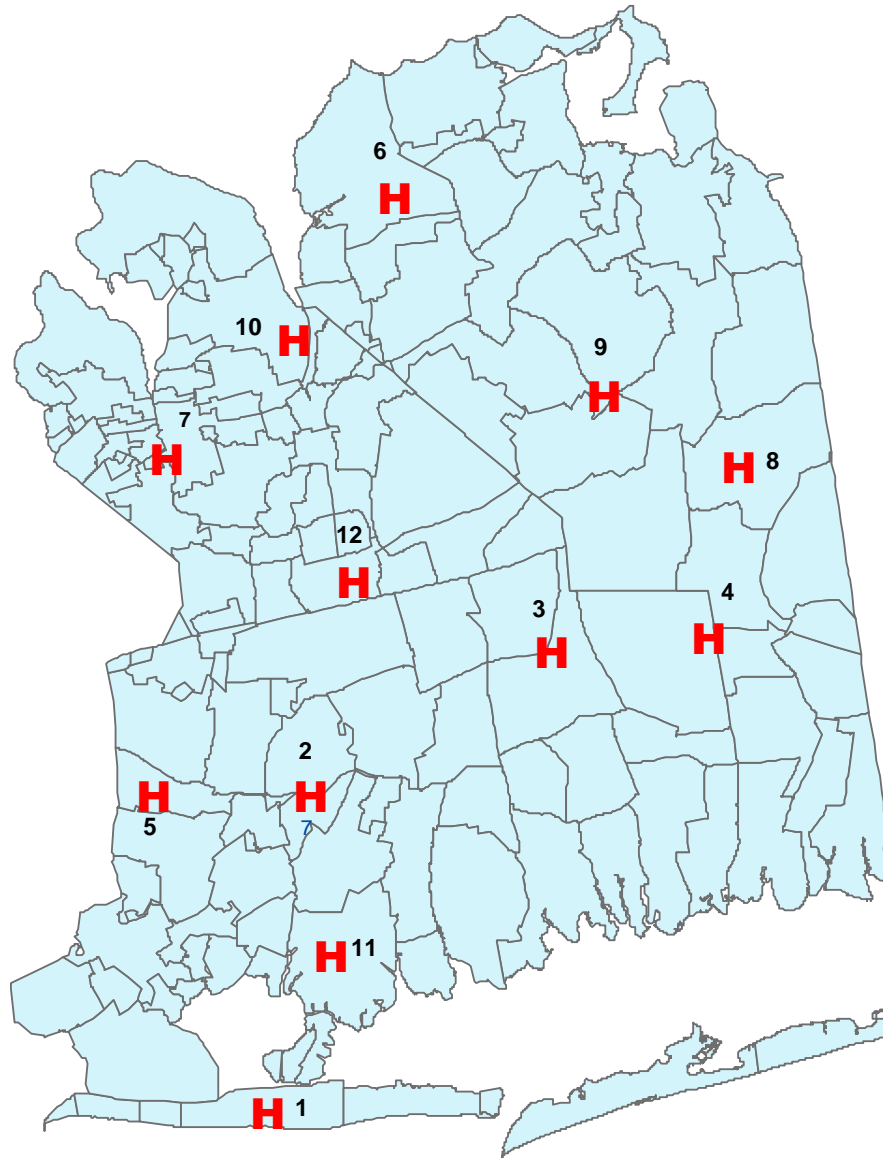
Winthrop-University Hospital

259 First Street, Mineola, NY 11501

Winthrop-University Hospital is a 591-bed acute care facility providing medical, surgical, pediatric, and obstetrical services and is also designated as a Level I Regional Trauma Center. Since 1996, it has been affiliated with South Nassau Communities Hospital under the parent corporation called Winthrop South Nassau University Health System, Inc. It is Long Island's first voluntary and oldest not-for-profit hospital in Nassau and Suffolk Counties and is also a member of the LIHN.

Admissions: 29,718, ER Visits: 49,279

HOSPITALS in NASSAU COUNTY



- 1 – Long Beach Medical Center
- 2 – Mercy Medical Center
(Catholic Health Services of Long Island)
- 3 – Nassau University Medical Center (NHCC)
- 4 – New Island Hospital
- 5 – Franklin Hospital (NSUH)
- 6 – Glen Cove Hospital (NSUH)
- 7 – North Shore University Hospital (NSUH)

- Long Beach
Rockville Centre
- East Meadow
Bethpage
- Franklin Square
Glen Cove
Manhasset

- 8 – Plainview Hospital (NSUH)
- 9 – Syosset Hospital (NSUH)
- 10 – St. Francis Hospital
(Catholic Health Services of Long Island)
- 11 – South Nassau Communities Hospital
(New York Presbyterian Healthcare System)
- 12 – Winthrop University Hospital
(New York Presbyterian Healthcare System)

- Plainview
Syosset
Roslyn
- Oceanside
- Mineola

COMMUNITY HEALTH CENTERS

NASSAU HEALTH CARE CORPORATION

Elmont Health Center

161 Hempstead Turnpike, Elmont, NY 11003 (516) 571-8200
Services: Primary Care/Specialty
Hours: M,W,TH,F – 9am-12pm & 1pm-4pm, Tues – 5pm-8pm

Freeport-Roosevelt Health Center

460 Main Street, Freeport, NY 11520 (516) 571-8600
Services: Primary Care/Specialty
Hours: M,W,TH,F – 9am-12pm & 1pm-4pm, Tues – 5pm-8pm

Hempstead Health Center

100 Main Street, Hempstead, NY (516) 572-1300
Services: Primary Care/Specialty
Hours: M,W,TH,F – 9am-12pm & 1pm-4pm, Tues – 5pm-8pm

Inwood-Lawrence Health Center

270 Lawrence Avenue, Lawrence, NY (516) 571-7874
Services: Primary Care/Specialty
Hours: M,W,TH,F – 9am-12pm & 1pm-4pm, Tues – 5pm-8pm

Westbury/New Cassel Health Center

682 Union Avenue, Westbury, NY (516) 571-9500
Services: Primary Care/Specialty
Hours: M,W,TH,F – 9am-12pm & 1pm-4pm, Tues – 5pm-8pm

Long Beach Satellite Center

615 Riverside Boulevard, Long Beach, NY (516) 571-7795

Roosevelt Jr.-Sr. High School School-Based Program

One Wagner Avenue, Roosevelt, NY (516) 867-8551

NORTH SHORE UNIVERSITY HOSPITAL HEALTH SYSTEM

NSLIJ Pediatric Mobile Health Center

Mobile Site: 120 Greenwich Street, Hempstead, NY 11550 (888) 207-3714
Services: Pediatric Care
Hours: M,T,TH – 9am-5pm, W,F – 1pm-5pm

PLANNED PARENTHOOD

Glen Cove Center

110 School Street, Glen Cove, NY 11542 (516) 750-2500
Services: Primary Care, OB/GYN & Family Planning
Hours: M – 1pm-7:30pm, T – 9:30am-4pm, W – 1pm-7pm, TH – 10am-5pm, F – 10am-12pm, S – 9am-1pm

Hempstead Center

540 Fulton Avenue, Hempstead, NY 11550 (516) 750-2500
Services: Primary Care, OB/GYN & Family Planning
Hours: M-TH – 9am-8pm, F,S – 9am-4pm

Massapequa Center

35 Carmans Road, Massapequa, NY 11758 (516) 750-2500
Services: Primary Care, OB/GYN & Family Planning
Hours: M, W – 9:30am-6pm, T,TH – 9:30am-4pm, S – 9:30am-12pm

HIV/AIDS SERVICES

African-American Health, Education & Development Foundation (AHEAD) (516) 538-0656 Education, information & advocacy	Hempstead, NY
AIDS Drug Assistance Program (ADAP) 1-800-542-2437 Assists with payment for certain HIV-related drugs and outpatient care	Albany, NY
Catholic Charities (516) 623-4420 Dental program	Freeport, NY
The Center for Rapid Recovery (516) 292-6449 Substance abuse program	Hempstead, NY
Circulo de la Hispanidad (516) 292-2433, 292-6853, 889-3869 Case-management, housing resources and transportation	Hempstead, NY Long Beach, NY
Economic Opportunity Commission of Nassau County, Inc. (EOC) (516) 292-9710 Provides financial assistance, food pantry	Hempstead, NY
Education Assistance Corporation (E.A.C.) (516) 489-7733 HIV/AIDS Meals-on-Wheels program	Hempstead, NY
Federation Employment & Guidance Service, Inc. (FEGS) (516) 485-5710, 496-7550 Mental health and client advocacy	Hempstead, NY Syosset, NY
Five Towns Community Center, Inc. (516) 505-9177 Case Management, pre-release and corrections outreach, alcohol & substance abuse program	Hempstead, NY
Hispanic Counseling Center (516) 538-2613 Mental Health, alcohol & substance abuse program	Hempstead, NY
Long Island Association for AIDS Care (LIAAC) 1-877-TO-LIAAC Case management, client advocacy, alcohol and substance abuse program, prevention education programs, legal clinic, emergency financial assistance, food pantry, home delivered meal program	Huntington, NY
Long Island Minority AIDS Coalition (631) 225-5500 Health education, treatment adherence	Lindenhurst, NY
Nassau County Youth Board (516) 227-7104 Teen peer education program	Uniondale, NY
Nassau-Suffolk Law Services (516) 292-8100 Legal support	Hempstead, NY
New York State Department of Health AIDS Institute 1-800-462-6785 Anonymous testing and counseling	Hempstead, NY
NHCC Nassau University Medical Center (NUMC) (516) 572-6506 Ambulatory/Outpatient medical treatment, confidential testing and counseling	East Meadow, NY
<ul style="list-style-type: none"> • NHCC Freeport-Roosevelt Health Center (516) 571-8600 • NHCC Westbury-New Cassel Health Center (516) 571-9500 Primary medical care, confidential testing and counseling	Freeport, NY Westbury, NY
North Shore University Hospital at Manhasset ((516) 562-4280 Center for AIDS Research and Treatment Ambulatory/Outpatient medical treatment, mental health and alcohol & substance abuse program	Manhasset, NY
Planned Parenthood of Nassau County, Inc. (516) 750-2500 Confidential testing, counseling and supportive program for women and men	Hempstead, NY

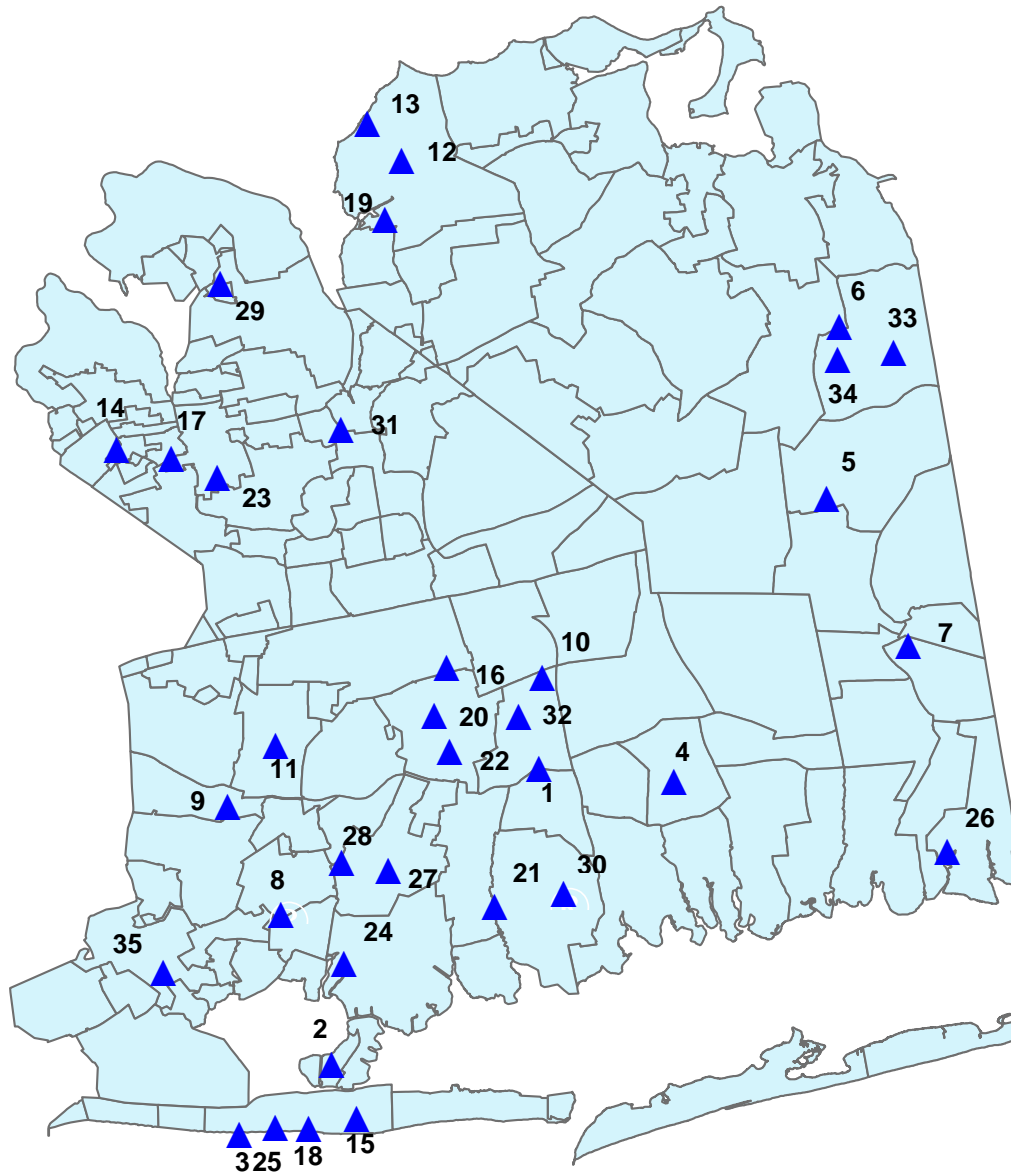
NASSAU COUNTY NURSING HOMES

A. HOLLY PATTERSON EXTENDED CARE FACILITY 875 Jerusalem Avenue, Uniondale, NY 11553 (516) 572-1400	<i>Certified Beds: 889</i>
BAYVIEW NURSING AND REHABILITATION CENTER One Long Beach Road, Island Park, NY 11558 (516) 432-0300	<i>Certified Beds: 185</i>
BEACH TERRACE CARE CENTER 640 West Broadway, Long Beach, NY 11561 (516) 431-4400	<i>Certified Beds: 182</i>
BELAIR CARE CENTER, INC. 2478 Jerusalem Avenue, Bellmore NY 11710 (516) 826-1160	<i>Certified Beds: 102</i>
CENTRAL ISLAND HEALTHCARE 825 Old Country Road, Plainview, NY 11803 (516) 433-0600	<i>Certified Beds: 202</i>
COLD SPRING HILLS CENTER FOR NURSING AND REHABILITATION 378 Syosset-Woodbury Road, Woodbury, NY 11797 (516) 622-7700	<i>Certified Beds: 672</i>
DALEVIEW CARE CENTER 574 Fulton Street, Farmingdale, NY 11735 (516)964-9800	<i>Certified Beds 142</i>
EAST ROCKAWAY PROGRESSIVE CARE FACILITY 243 Atlantic Avenue, Lynbrook, NY 11563 (516) 599-2744	<i>Certified Beds: 100</i>
FRANKLIN HOSPITAL MEDICAL CENTER 900 Franklin Avenue, Valley Stream, NY 11580 (516) 256-6700	<i>Certified Beds: 120</i>
FULTON COMMONS CARE CENTER, INC. 60 Merrick Avenue, East Meadow, NY 11554 (516) 222-9300	<i>Certified Beds: 280</i>
GARDEN CARE CENTER 135 Franklin Avenue, Franklin Square, NY 11010 (516) 775-2100	<i>Certified Beds: 150</i>
GLEN COVE CENTER FOR NURSING AND REHABILITATION 6 Medical Plaza, Glen Cove, NY 11542 (516) 671-9010	<i>Certified Beds: 154</i>
GLENGARIFF CORPORATION Dosoris Lane, Glen Cove, NY 11542 (516) 676-1100	<i>Certified Beds: 262</i>
GRACE PLAZA NURSING AND REHABILITATION CENTER 15 St Pauls Place, Great Neck, NY 11021 (516) 466-3001	<i>Certified Beds: 214</i>
GRANDELL REHABILITATION AND NURSING CENTER 645 W. Broadway, Long Beach, NY 11561 (516) 889-1100	<i>Certified Beds: 278</i>
HEMPSTEAD PARK NURSING HOME 800 Front Street, Hempstead, NY 11550 (516) 705-9700	<i>Certified Beds: 251</i>
HIGHFIELD GARDENS CARE CENTER OF GREAT NECK 199 Community Drive. Great Neck, NY 11021 (516) 365-9229	<i>Certified Beds: 200</i>
KOMANOFF CTR FOR GERIATRIC & REHAB MEDICINE 375 East Bay Drive, Long Beach, NY 11561 (516) 897-1220	<i>Certified Beds: 200</i>
MARQUIS CARE CENTER 2 Medical Plaza, Glen Cove, NY 11542 (516) 671-0858	<i>Certified Beds: 102</i>
MAYFAIR CARE CENTER 100 Baldwin Road, Hempstead, NY 11550 (516) 538-7171	<i>Certified Beds: 200</i>

NASSAU COUNTY NURSING HOMES

MEADOWBROOK CARE CENTER, INC 320 West Merrick Road, Freeport, NY 11520 (516) 377-8200	<i>Certified Beds: 280</i>
NASSAU EXTENDED CARE FACILITY One Greenwich Street, Hempstead, NY 11550 (516) 565-4800	<i>Certified Beds: 280</i>
NORTH SHORE UNIVERSITY HOSPITAL CENTER FOR EXTENDED CARE & REHABILITATION 300 Community Drive, Manhasset, NY 11030 (516) 562-8000	<i>Certified Beds: 256</i>
OCEANSIDE CARE CENTER, INC. 2914 Lincoln Avenue, Oceanside, NY 11572 (516) 536-2300	<i>Certified Beds: 100</i>
PARK AVENUE EXTENDED CARE FACILITY 425 National Boulevard, Long Beach, NY 11561 (516) 431-2600	<i>Certified Beds: 240</i>
PARKVIEW CARE AND REHABILITATION CENTER, INC. 5353 Merrick Road, Massapequa, NY 11758 (516) 798-1800	<i>Certified Beds: 169</i>
ROCKVILLE NURSING CENTER, INC. 41 Maine Avenue. Rockville Centre, NY 11570 (516) 536-7730	<i>Certified Beds: 158</i>
ROCKVILLE SKILLED NURSING & REHABILITATION CENTER, LLC 50 Maine Avenue, Rockville Centre, NY 11570 (516) 536-8000	<i>Certified Beds: 66</i>
SANDS POINT CENTER FOR HEALTH & REHABILITATION 1440 Port Washington Boulevard, Port Washington, NY 11050 (516) 719-9400	<i>Certified Beds: 180</i>
SOUTH SHORE HEALTHCARE 275 West Merrick Road, Freeport, NY 11520 (516) 623-4000	<i>Certified Beds: 100</i>
SUNHARBOR MANOR 255 Warner Avenue, Roslyn Heights, NY 11577 (516) 621-5400	<i>Certified Beds: 266</i>
TOWNHOUSE EXTENDED CARE FACILITY 755 Hempstead Turnpike, Uniondale, NY 11553, (516) 565-1900	<i>Certified Beds: 280</i>
WHITE OAKS NURSING HOME 8565 Jericho Turnpike, Woodbury, NY 11797 (516) 367-3400	<i>Certified Beds: 200</i>
WOODBURY NURSING HOME 8533 Jericho Turnpike, Woodbury, NY 11797 (516) 692-4100	<i>Certified Beds: 123</i>
WOODMERE REHABILITATION & HEALTH CARE CENTER, INC. 121 Franklin Place, Woodmere, NY 11598 (516) 374-9300	<i>Certified Beds: 336</i>

NURSING HOMES in NASSAU COUNTY



- 1 – A.Holly Patterson Extended Care Facility
- 2 – Bayview Nursing and Rehabilitation Center
- 3 – Beach Terrace Care Center
- 4 – Belair Care Center, Inc.
- 5 – Central Island Healthcare
- 6 – Cold Spring Hills Nursing & Rehabilitation Center
- 7 – Daleview Care Center
- 8 – East Rockaway Progressive Care Facility
- 9 – Franklin Hospital Medical Center
- 10 – Fulton Commons Care Center, Inc.
- 11 – Garden Care Center
- 12 – Glen Cove Center for Nursing & Rehabilitation
- 13 – Glengariff Corporation
- 14 – Grace Plaza Nursing & Rehabilitation Center
- 15 – Grandell Rehabilitation & Nursing Center
- 16 – Hempstead Park Nursing Home
- 17 – Highfield Gardens Care Center of Great Neck
(Operated by Wedgewood Care Center, Inc.)

- Uniondale
- Island Park
- Long Beach
- No. Bellmore
- Plainview
- Woodbury
- Farmingdale
- Lynbrook
- Valley Stream
- East Meadow
- Franklin Square
- Glen Cove
- Glen Cove
- Great Neck
- Long Beach
- Hempstead
- Great Neck

- 18 – Komanoff Center for Geriatric & Rehab Medicine
- 19 – Marquis Care Center
- 20 – Mayfair Care Center
- 21 – Meadowbrook Care Center, Inc.
- 22 – Nassau Extended Care Facility
- 23 – NSUH Center for Extended Care & Rehabilitation
- 24 – Oceanside Care Center, Inc.
- 25 – Park Avenue Extended Care Facility
- 26 – Parkview Care & Rehabilitation Center, Inc.
- 27 – Rockville Nursing Center, Inc.
- 28 – Rockville Skilled Nursing & Rehabilitation Center
- 29 – Sands Point Center for Health & Rehabilitation
- 30 – South Shore Healthcare
- 31 – Sunharbor Manor
- 32 – Townhouse Extended Care Facility
- 33 – White Oaks Nursing Home
- 34 – Woodbury Nursing Home
- 35 – Woodmere Rehabilitation & Health Care Center

- Long Beach
- Glen Cove
- Hempstead
- Freeport
- Hempstead
- Manhasset
- Oceanside
- Long Beach
- Massapequa
- Rockville Centre
- Rockville Centre
- Port Washington
- Freeport
- Roslyn Heights
- Uniondale
- Woodbury
- Woodbury
- Woodmere

EXHIBIT 6LPHS 7

COMMUNITY PARTNERS AND COLLABORATIONS

Mobilizing community partnerships is one of the ten essential public health services. Below is a partial listing of LHD partnerships, collaborations and advisory groups that contribute to our overall mission.

Organization

Mission

ADVISORY GROUPS

Nassau County HIV Commission
(516) 571-2019

Community member advisory board to the LHD which works actively with county leaders to educate the public on HIV/AIDS infection prevention.

Nassau County Minority Health Task Force
(516) 571-2260

Collaboration of the community, health care providers, county government officials, NCDMH and the LHD to eliminate health care disparities and improve the quality of care for minorities.

Nassau Suffolk Hospital Council, Inc. (NSHC)
(631) 435-3000

To enhance health care for all Long Islanders by representing the interests of its 23 member hospitals before lawmakers, regulatory agencies, the media, and the public.

ADVOCACY AND POLICY

American Cancer Society (ACS)
(516) 921-6016

Work together in support of New York State's Clean Indoor Air Act and cancer care and treatment.

Health & Welfare Council of Long Island (HWCLI)
(516) 483-1110

To respond to the needs of vulnerable families and individuals by promoting the development of public policies and services.

IPro, Inc.
(516) 326-7767

Oversight responsibility for all planning, data collection, analysis and reporting for the NYSDOH statewide monitoring contracts to assess and improve the value of health care services received by consumers.

Nassau Suffolk Adult Immunization Coalition
(516) 571-1680

To increase the adult immunization level.

National Black Leadership on AIDS (NBLCA)
(212) 614-0023

Increase awareness and community involvement to develop preventative solutions for HIV/AIDS.

Tobacco Action Coalition of Long Island
(631) 231-5864 x11

To increase the acceptance of non-smoking as the social norm through media advocacy, policy initiatives and existing tobacco education and control programs.

COMMUNITY HEALTH

American Heart Association
(516) 777-8447

Promote "Search Your Heart", a faith based healthy heart awareness/education initiative to reduce heart disease in minority populations.

Coalition to Eliminate Racial and Ethnic Disparities in Healthcare and A.H.E.A.D.
(516) 538-0656/(631) 225-5500

To improve cultural competency among health care providers.

Coalition for Community Well Being, Aubrey Lewis, MD
(516) 565-1203

Participate in health fair screenings and conferences.

Coordinated School Health Center (BOCES)
(631) 242-1128

To promote healthy schools and strengthen coordination and support for healthy schools.

Cornell Cooperative Extension of Nassau County (CCE)
516 292-7990

To provide communities with nutrition, parenting, agriculture, workplace wellness, and youth development programs.

Economic Opportunity Commission of Nassau County (EOC)
(516) 292-9710

To provide low-income and minority individuals of the county the opportunity for education, training, employment, health care and decent housing.

Long Island Association for AIDS Care (LIAAC)
1-877-TO-LIAAC

Under contract to provide HIV prevention services.

Long Island Minority AIDS Coalition (LIMAC)
(631) 225-5500

Under contract to provide HIV prevention services.

Long Island Non Motorized Traffic Study (LINMTS)
(631) 952-6632

Promotion of safe pedestrian, bicycle and other non-motorized transportation through education, engineering and policy development.

Nassau-Suffolk Ryan White HIV Health Services Planning Council
(631) 940-3711

Work with the Policy Advisory and Comprehensive Service Plan Development Committees to ensure the provision of emergency services to HIV-positive individuals.

New York State Public Health Association
(518) 427-5835

To support the improvement of community and environmental health through education and prevention.

Perinatal Services Network
(516) 572-0954

Comprised of member organizations which provide health, social, economic, legal and other relevant services, Information and referrals to pregnant and parenting women regardless of citizenship or ability to pay.

EDUCATIONAL INSTITUTIONS

Adelphi University
(516) 877-4413

VITAL SIGNS Project to analyze the social health of Long Island's peoples and communities with particular focus on disparities amidst affluence.

Hofstra University
(516) 463-5883

Internship affiliation.

New York College of Osteopathic Medicine (NYCOM)
(516) 686 3777

Partner in emergency preparedness.

SUNY Farmingdale
(631) 420-2060

Partner in oral health initiative.

SUNY Stony Brook
(631) 444-2341

Placement for preventative medicine residents.

ENVIRONMENTAL HEALTH

Beach Information Network

LHD and beach operators share information regarding the beaches.

Cedar Creek Health Risk Assessment Committee

To monitor health concerns in the area because of the existence of the sewage treatment plant.

Coalition to Save Hempstead Harbor

Organization collects surface water samples and submits to the LHD Lab for analysis for use in the LHD's beach water monitoring program.

Friends of the Bay

Organization collects surface water samples in the Oyster Bay area and submits to the LHD Lab for analysis for use in the LHD's beach water monitoring program.

Nassau County Soil and Water Conservation District (516) 454-4872/0900

To conserve soil and water resources, control sediment and erosion, reduce floodwater, preserve natural resources, assist in the drainage and irrigation of agricultural lands, preserve wildlife and protect public lands. Members are appointed by the Nassau County legislature.

New York State Restaurant Association (NYSRA) (516) 752-0707

To improve worker safety, especially related to indoor air quality.

Greater Long Island Clean Cities Coalition (631) 969-3700

To advance economic, environmental and energy security by supporting decisions to adopt practices that contribute to the reduction of petroleum consumption and developing public and private partnerships to promote alternative fuels and vehicles, fuel blends, fuel economy, hybrid vehicles and idle reduction awareness.

Long Island Groundwater Research Institute Marine Sciences Research Center Stony Brook University 631-632-8674

Fundamental research designed to increase the understanding of the processes that characterize the coastal ocean and the atmosphere and to apply research to solve problems that result from uses and misuses of the environment.

Long Island Veterinarian Association, Rabies Control

The LHD exchanges information regarding rabies control.

HEALTH CARE PROVIDERS

Asthma Coalition of Long Island (ACLI) (631) 231-5864 x12

To reduce the burden of asthma through awareness/education and disease management initiatives.

Nassau Partnership for Healthy Communities (NPHC) (516) 465-3186

To improve quality of and access to health care for poor and underserved communities.

Nassau University Medical Center (NUMC) (516) 572-0123

Under contract to provide essential public health services through its community health centers.

Planned Parenthood of Nassau County (PPNC) (516) 750-2500

Work jointly to reduce HIV infection and unintended pregnancy.

PROFESSIONAL SOCIETIES

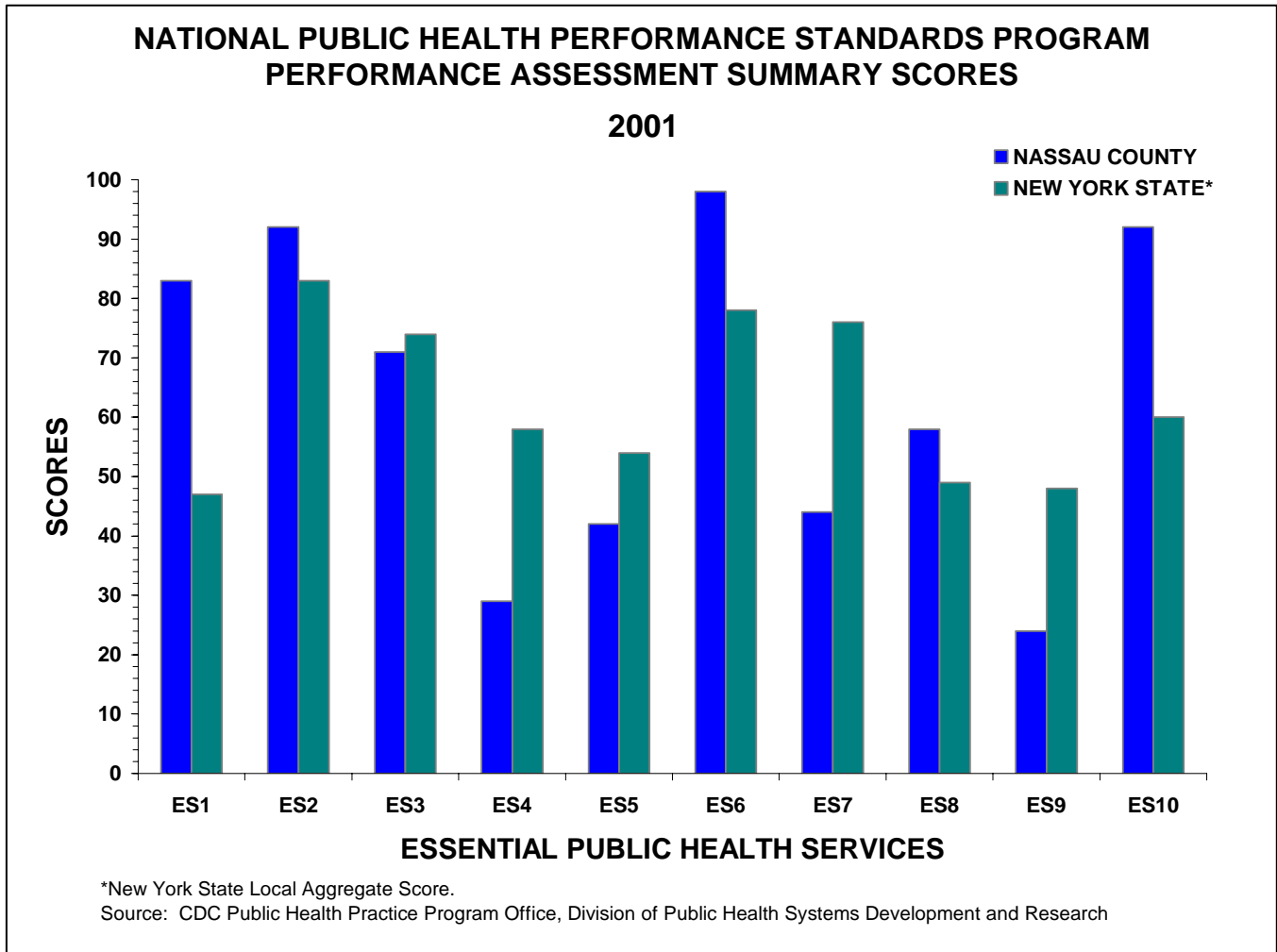
Nassau County Medical Society (NCMS)
(516) 832-2300

To preserve the doctor-patient relationship, to assure access to quality medical care for all, and to voice the ethical perspective of physicians in their provision of medical care.

American Academy of Pediatrics – (AAP NY Chapter 2)
(516) 326-0310

To achieve optimal physical, mental and social health and well-being for all infants, children, adolescents and young adults by supporting the professional needs of its members.

Exhibit 6LPHS 8



- ES 1 Monitor health status to identify community health problems.
- ES 2 Diagnose and investigate health problems and health hazards in the community.
- ES 3 Inform, educate and empower people about health issues.
- ES 4 Mobilize community partnerships to identify and solve health problems.
- ES 5 Develop policies and plans that support individual and community health efforts.
- ES 6 Enforce laws and regulations that protect health and ensure safety.
- ES 7 Link people to needed personal health services and assure provision of health care when otherwise unavailable.
- ES 8 Assure a competent public health and personal health care workforce.
- ES 9 Evaluate effectiveness, accessibility and quality of personal and population-based health services.
- ES 10 Research for new insights and innovative solutions to health problems.

APPENDIX 7 - Community Health Assessment Indicators

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New York State County Health Assessment Indicators Overview

The New York State County Health Assessment Indicator (CHAI) Reports consist of a series of tables presenting selected public health indicators by health topic areas. These public health indicators and presentation format were developed with input from state and local health department representatives. The health topic areas are as follows:

Cancer, Child/Adolescent Health, Cirrhosis/Diabetes, Family Planning and Natality, Health Behaviors, Heart Disease and Stroke, HIV/AIDS and Sexually Transmitted Disease, Immunization and Infectious Diseases, Injury Mortality/Morbidity, Maternal and Infant Health and Respiratory Diseases.

Several resources were used in compiling these tables including:

- New York State birth, death, and fetal death files for mortality and natality rates.
- Statewide Planning and Research Cooperative Systems (SPARC) files, based on hospital discharges, for information on morbidity.
- Department of Health disease registries, including cancer, AIDS/HIV, communicable disease, and sexually transmitted disease.
- Program-based systems. (STD)
- The Expanded Behavioral Risk Factor Surveillance System (Expanded BRFSS), based on a household telephone survey, for information on health behaviors.
- Other non-health department sources such as the US Census Bureau Small Area Data Set and the NYS Departments of Education, Labor, and Motor Vehicles.

Most indicators are presented using the last three years of available data for the numerator, and the three-year average for the county and state rates. The mid-year population (2001 for 2000-2002 rate) was used for the denominator in generating these rates. County rates were compared to New York State, New York State (excl. NYC) for "upstate" counties, or New York City for "city" counties/boroughs, and tested to see whether the two rates were "significantly" different at the 95% level. A quartile ranking of the county rate, in relation to the rates of all 62 NYS counties, was also included for each indicator (1- most favorable, 4- least favorable). The Healthy People 2010 Goal is also presented, if available.

Mortality and hospitalization-based indicators are presented as both crude and age-adjusted rates. The standard population used for adjustment was the 2000 United States population. Age-adjustment allows for the comparison of rates between counties because they are less influenced by differences in the county age distribution.

Behavior/Risk Indicators were generated using the Expanded BRFSS. The Expanded BRFSS was a telephone-based survey collecting information on self-reported health risk behaviors in adult New Yorkers. The Expanded BRFSS was conducted from July 2002 through 2003 in 38 localities (individual counties and county groupings) comprising the entire state. The Expanded BRFSS questionnaire was constructed of standard BRFSS items and modules developed by the Centers for Disease Control and Prevention. Questionnaire development began with the selection of a common set of core items and modules to be asked in each of the 38 localities. Each locality was then allowed to select optional items and modules of particular interest to their respective area to complete the balance of their specific questionnaire.

Expanded BRFSS-based indicators present the weighted percent and its 95% confidence interval. Statewide Expanded BRFSS data are available only on items contained in the "core" questionnaire. For county-selected optional items, the Expanded BRFSS results are compared to statewide BRFSS data. Quartile ranks are based on county or county groupings that collected that item on their questionnaire. Rates based on fewer than 20 events in the numerator will be highlighted (*) as unstable. The numerator and rates are suppressed if based on one or two events.

Exhibit 7CHAI 2

**CANCER
NASSAU COUNTY
1997-2001**

Indicator	5 Year Total	County Rate	NYS Rate	Sig.Dif.	NYS Rate exc NYC	Sig.Dif.	Quartile	HP2010 Goal	HP2010 Goal Met?
AGE-ADJUSTED INCIDENCE									
-Colon and Rectum	4,806	63.1	62.2	No	63.5	No	2nd	N/A	N/A
-Lung and Bronchus	5,131	67.0	67.1	No	73.6	Yes	1st	N/A	N/A
-Female Breast	5,864	144.3	131.4	Yes	139.0	Yes	4th	N/A	N/A
-Prostate	5,742	171.7	163.6	Yes	166.7	No	3rd	N/A	N/A
AGE-ADJUSTED MORTALITY									
-Colon and Rectum	1,519	20.0	22.3	Yes	22.5	Yes	1st	13.9	No
-Lung and Bronchus	3,632	47.3	50.1	Yes	55.3	Yes	1st	44.9	No
-Melanoma of the Skin	233	3.1	2.3	Yes	2.7	No	3rd	2.5	No
-Female Breast	1,290	30.3	28.9	No	28.9	No	3rd	22.3	No
-Cervix Uteri	96	2.4	3.0	No	2.5	No	2nd	2.0	No
-Ovary	419	9.7	9.1	No	9.7	No	3rd	N/A	N/A
-Prostate	778	27.0	30.5	Yes	30.3	Yes	1st	28.8	Yes
AGE-ADJUSTED CANCER INCIDENCE AND PERCENT EARLY STAGE DIAGNOSIS									
-Colon and Rectum	N/A	41%	40%	No	43%	Yes	2nd	50%	No
-Lung and Bronchus	N/A	26%	26%	No	27%	No	2nd	N/A	N/A
-Melanoma of the Skin	N/A	85%	81%	No	82%	No	2nd	90%	No
-Female Breast	N/A	66%	66%	No	68%	No	3rd	75%	No
-Cervical	N/A	55%	55%	No	58%	No	3rd	65%	No
-Ovary	N/A	24%	24%	No	23%	No	2nd	N/A	N/A
-Prostate	N/A	90%	87%	Yes	87%	Yes	1st	95%	No
% women 18+ years with pap smear in past 3 years (BRFSS) ^(a)	N/A	N/A	84.8	± 1.9	N/A	N/A	N/A	90	Yes
% women 40+ years with mammography screening in past 2 years(BRFSS) ^(b)	78.5	± 5.8	77.6	± 1.6	78.2	± 1.5	2nd	70	Yes

*: Fewer than 20 events in the numerator; therefore rate is unstable, s: Total suppressed for confidentiality, #: 95% confidence interval for BRFSS/Expanded BRFSS indicators

Definition:

^(a) Percentage of female respondents who indicated they have had a pap smear in the past 3 years.

^(b) Percentage of female respondents aged 50 or older who indicated they have had a mammogram and breast exam in the past 2 years.

Data notes:

For cancer mortality statistics, deaths are grouped according to ICD codes recorded on death certificates. All deaths received a ICD-9 code before year 1999 and a ICD-10 code thereafter. Standard Site Analysis categories for mortality data are available on the [SEER Cause of Death Recode](#) web page.

Incidence and Stage at Diagnosis Data are based on reports from hospitals and other health facilities that diagnose and treat cancer patients. All primary tumors receive a ICD-O-3 code indicating the anatomic site of origin. Standard Site Analysis categories for cancer data analysis are available on the [SEER Incidence Site Recode](#) web page. These data include only invasive malignant tumors. Data are presented for a five-year time period. Stage at diagnosis is determined based on the clinical information received from reporting facilities. Early stage is defined as invasive cancers that are limited to the tissue of origin. Patients for whom stage at diagnosis is unknown are not included in the calculation of percent of cancers diagnosed at an early stage.

Source: New York State Department of Health

**CHILD AND ADOLESCENT HEALTH
NASSAU COUNTY
2000-2002**

Indicator	3 Year Total	County Rate	NYS Rate	Sig. Dif.	NYS Rate exc NYC	Sig. Dif.	Quartile	HP2010 Goal	HP2010 Goal Met?
Childhood Mortality (per 100,000)									
1-4 years	44	21.9	26.7	No	27.0	No	2nd	25	Yes
5-9 years	21	7.5	12.3	No	11.4	No	2nd	14	Yes
10-14 years	32	11.2	14.6	No	13.6	No	2nd	17	Yes
Asthma Hospitalization rate per 10,000									
0-4 years	1,202	47.9	66.0	Yes	35.7	Yes	4th	25	No
5-14 years	716	12.7	22.2	Yes	10.2	Yes	4th	N/A	N/A
0-17 years	2,008	20.6	31.8	Yes	15.8	Yes	4th	17	No
Gastroenteritis hospitalization rate per 10,000 (0-4 yrs)	640	25.5	32.2	Yes	19.1	Yes	3rd	N/A	N/A
Otitis media hospitalization rate per 10,000 (0-4 yrs)	254	10.1	6.5	Yes	4.3	Yes	4th	N/A	N/A
Pneumonia hospitalization rate per 10,000 (0-4 yrs)	1,201	47.8	50.6	No	40.6	Yes	3rd	N/A	N/A
% children born in 1998 & 1999 screened for lead by age 2	22,600	66.2	N/A	N/A	63.7	Yes	3rd	N/A	N/A
Incidence rate among children <72 months of age with a confirmed blood lead levels $\geq 10\mu\text{g/dl}$ tested in 2000 and 2001 ^(a)	339	0.6	N/A	N/A	1.8	Yes	1st	N/A	N/A

*: Fewer than 20 events in the numerator; therefore rate is unstable

s: Total suppressed for confidentiality

Definition:

The rates are the number of deaths per 100,000 children in the specific age group.

The number of hospitalizations for asthma in a particular age group per 10,000 population in that age group. The ICD-9 code for asthma is 493.

The number of hospitalizations for gastroenteritis among children ages 0-4 years per 10,000 children in the specific age group. The ICD-9 codes for gastroenteritis are: 008.6, 008.8, 009.0-009.3, and 558.9.

The number of hospitalizations for otitis media among children ages 0 - 4 years per 10,000 children in the specific age group. The ICD-9 codes for otitis media are: 381 - 382.

The number of hospitalizations for pneumonia- among children ages 0 - 4 years per 10,000 children in the specific age group. The ICD-9 codes for pneumonia are: 480 - 486.

^(a) The proportion of children newly identified with a confirmed elevated blood lead level of $10\mu\text{g/dL}$ or greater per 100 children screened in the given time frame.

Data notes:

Vital Records: Information is extracted from birth, death and fetal death certificates. When percentages are calculated records with missing information for the indicator of interest are excluded from the calculation. Population based rates use population estimates provided by the US Census Bureau. ICD-10 codes are used for cause of death.

Statewide Planning and Research Cooperative System-SPARCS: Data on hospitalization are collected through the hospital inpatient discharge data system. Each hospitalization receives an ICD-9 code at discharge which indicates the primary reason for the hospitalization. Data are not available on events that did not result in a hospitalization, such as cases that were only treated in a hospital emergency room.

The New York State Lead Poisoning Prevention Program: This program collects and analyzes statewide data on the extent and severity of childhood lead poisoning.

The Indicator "% of children screened by age two" represents the Birth Cohort Screening Rate: This rate represents the total number of children that had been tested at least once for elevated blood lead levels before age twenty four months in a given birth year divided by the total number of births in the respective birth year (birth cohort). This proportion is then multiplied by 100 to represent the average screening rate per 100 children born in a given year by age two by geographic area.

Incidence rate: The number of children identified for the first time with a confirmed elevated blood lead level before age 72 months who had never been identified previously with a confirmed elevated blood lead level ($\geq 10\mu\text{g/dL}$) divided by the number of children that had a screening test in that given test year. Only children who did not previously have a confirmed elevated blood lead level are included in the screening denominator. This proportion is then multiplied by 100 to represent the average number of children newly identified per 100 children tested in the given time frame.

Total State lead rates are exclusive of New York City (NYC) because the New York State Childhood Lead Registry does not include NYC records. Comparable data generated by NYC staff are not available due to differences in methodology.

Source: New York State Department of Health

Exhibit 7CHAI 4

CIRRHOSIS & DIABETES NASSAU COUNTY 2000-2002

Indicator	3 Year Total	County Rate	NYS Rate	Sig.Dif.	NYS Rate exc NYC	Sig.Dif.	Quartile	HP2010 Goal	HP2010 Goal Met?
CIRRHOSIS									
Mortality rates per 100,000 (ICD10 K70,K73-K74)									
Crude	227	5.6	7.4	Yes	7.9	Yes	1st	N/A	N/A
Age-adjusted	227	4.9	7.2	Yes	7.3	Yes	1st	N/A	N/A
Hospitalization rates per 10,000 (ICD9 571)									
Crude	975	2.4	3.2	Yes	2.5	No	2nd	N/A	N/A
Age-adjusted	975	2.2	3.1	Yes	2.3	No	2nd	N/A	N/A
DIABETES									
Mortality rate per 100,000 (ICD10 E10-E14)									
Crude	551	13.7	20.5	Yes	19.8	Yes	1st	N/A	N/A
Age-adjusted	551	11.7	19.7	Yes	18.0	Yes	1st	N/A	N/A
Hospitalization rate per 100,000 (Primary dx ICD9 250)									
Crude	5,830	14.5	18.9	Yes	14.3	No	3rd	N/A	N/A
Age-adjusted	5,830	13.2	18.5	Yes	13.6	Yes	2nd	N/A	N/A
Hospitalization rate per 100,000 (Any dx ICD9 250)									
Crude	72,982	181.6	191.5	Yes	177.7	Yes	2nd	N/A	N/A
Age-adjusted	72,982	157.3	186.4	Yes	164.7	Yes	2nd	N/A	N/A
- Behavior/Risk Indicator (2003) -	County Rate	CI #	NYS Rate	CI #	Upstate	CI #			
Diabetes prevalence rate per 100 adults	5.8	± 1.9	7.2	± 0.6	6.6	± 0.5	1st	N/A	N/A

*: Fewer than 20 events in the numerator; therefore rate is unstable, s: Total suppressed for confidentiality, #: 95% confidence interval for BRFSS/Expanded BRFSS indicators

Definition:

The number of deaths due to Cirrhosis per 100,000 population. The codes used for the Cirrhosis mortality are ICD-10 codes: K70, K73-K74. **

The number of hospitalizations due to Cirrhosis per 10,000 population. The ICD9 code for Cirrhosis is: 571. **

The number of deaths due to diabetes per 100,000 population. The ICD-10 codes used for diabetes are: E10-E14. **

The number of hospitalizations due to diabetes per 10,000 population. The ICD 9 code used for Diabetes is: 250. Only hospitalizations with diabetes as the primary diagnosis are included.

The percent of adults that reported they have been told by a health professional that they have diabetes.

Data notes:

Expanded BRFSS: All data relates to adults 18 years of age or older. The Expanded BRFSS was a telephone-based survey that collects information on self-reported health related behaviors. Between July 2002 and July 2003, the Expanded BRFSS was conducted in 38 localities (individual counties and county groupings) comprising the entire state.

Also, see previous.

** The standard population used for age adjustment was the 2000 US population.

Source: New York State Department of Health

Exhibit 7CHAI 5

**FAMILY PLANNING AND NATALITY
NASSAU COUNTY
2000-2002**

Indicator	3 Year Total	County Rate	NYS Rate	Sig. Dif.	NYS Rate exc NYC	Sig. Dif.	Quartile	HP2010 Goal	HP2010 Goal Met?
Pregnancy Rate (15-44 years) per 1,000	65,995	82.1	93.8	Yes	77.4	Yes	4th	N/A	N/A
Teen Pregnancy Rate per 1,000									
- 10-14years	83	0.6	1.7	Yes	1.0	Yes	2nd	N/A	N/A
- 15-17 years	1,485	19.5	42.2	Yes	28.0	Yes	1st	43	Yes
- 15-19 years	4,061	33.7	68.8	Yes	47.4	Yes	1st	N/A	N/A
% of Births within 24 months of previous pregnancy	11,254	22.8	20.8	Yes	23.4	Yes	2nd	6	No
% of births to teens (10-17 years)	594	1.2	2.7	Yes	2.4	Yes	1st	N/A	N/A
% of births to women 35+ years	13,397	27.1	18.7	Yes	19.6	Yes	4th	N/A	N/A
Fertility rate (Birth/pop 15-44 years per 1,000)	49,319	61.3	60.2	Yes	58.5	Yes	4th	N/A	N/A
Teen birth rate (Births 10-17/pop 10-17 per 1,000)	594	2.8	6.6	Yes	5.3	Yes	1st	N/A	N/A
Abortion Ratio (induced abortions per 100 live births)									
15-19 years	2,264	132.6	110.7	Yes	78.2	Yes	4th	N/A	N/A
All ages	12,501	25.3	48.5	Yes	26.8	Yes	3rd	N/A	N/A

*: Fewer than 20 events in the numerator; therefore rate is unstable, s: Total suppressed for confidentiality

Definition:

Pregnancies are the sum of the number of live births, induced terminations of pregnancies, and all fetal deaths. Pregnancy rates are the number of pregnancies in a particular age group per 1,000 females in that same age group.

Birth Interval: The percentage of total births to women that had had a previous pregnancy within 24 months of the current birth.

The percent of total births that were to females in particular age groups.

The number of live births per 1,000 female population aged 15-44.

The number of live births to teens aged 10-17 per 1,000 female population 10-17.

The abortion ratio is the number of induced abortions per 100 live births in particular age groups.

Data notes:

Vital Records: Information is extracted from birth, death and fetal death certificates. When percentages are calculated records with missing information for the indicator of interest are excluded from the calculation. Population based rates use population estimates provided by the US Census Bureau. ICD-10 codes are used for cause of death.

Source: New York State Department of Health

HEALTH RISKS AND HEALTH BEHAVIORS NASSAU COUNTY 2000-2002

Indicator	3 Year Total	County Rate	NYS Rate	Sig. Dif.	NYS Rate exc NYC	Sig. Dif.	Quartile	HP2010 Goal	HP2010 Goal Met?
% children underweight (0-4 years, low SES)	543	7.1	7.4	No	6.4	Yes	3rd	N/A	N/A
% children overweight (2-4 years, low SES)	768	21.2	16.3	Yes	14.2	Yes	4th	N/A	N/A
- Behavior/Risk Indicator (2003) -	County Rate	CI #	NYS Rate	CI #	Upstate	CI #			
% adults overweight or obese (BMI 25+)	52.1	± 4.8	56.7	± 1.2	57.6	± 1.1	1st	N/A	N/A
% adults that participated in leisure time physical activity in last 30 days	75.6	± 4.3	74.6	± 1.0	77.6	± 1.0	3rd	N/A	N/A
% adults smoking cigarettes	17.7	± 3.5	20.3	± 0.9	22.1	± 0.9	1st	12	No
% adult smokers that tried to quit smoking for one day or longer	57.6	± 10.9	58.0	± 2.3	55.6	± 2.3	2nd	75	No
% adults that binge drink	10.8	± 2.8	14.1	± 0.8	15.2	± 0.9	1st	N/A	N/A
% adults eating 5 or more servings of fruit or vegetables daily	N/A	± 0.0	25.8	± 1.4	N/A	N/A	N/A	N/A	N/A

*: Fewer than 20 events in the numerator; therefore rate is unstable, s: Total suppressed for confidentiality, #: 95% confidence interval for BRFSS/Expanded BRFSS indicators

Definition:

The percent of respondents that reported they ate at least five or more servings of fruits and vegetables in the past day.

The percent of respondents with body mass index (BMI) equal to or greater than 25. BMI is defined as weight in kilograms divided by height in meters squared w/h².

The percent of respondents who report they participated in some type of physical activity during their leisure time at least one in the last 30 days.

The percent of respondents who report having five or more drinks on an occasion, one or more times in the past 30 days.

The percent of respondents who have smoked 100 cigarettes in their lifetime and reported smoking every day or some days.

The percent of respondents who tried to quit smoking for one day or longer during the past 12 months.

Underweight is defined as < 5th percentile based on 2000 CDC growth chart percentiles for weight-for-length for children under 2 years of age and BMI-for-age for children 2 years of age and older.

Overweight defined as at or above the 95th percentile based on BMI-for-age.

Data notes:

Expanded BRFSS: All data relates to adults 18 years of age or older. The Expanded BRFSS was a telephone-based survey that collects information on self-reported health related behaviors. Between July 2002 and July 2003, the Expanded BRFSS was conducted in 38 localities (individual counties and county groupings) comprising the entire state.

Pediatric Nutrition Surveillance System - WIC Program: This data system in the Division of Nutrition provides nutrition related information on low-income infants and children enrolled in the WIC Program

Source: New York State Department of Health

Exhibit 7CHAI 7

HEART DISEASE AND STROKE

NASSAU COUNTY

2000-2002

Indicator	3 Year Total	County Rate	NYS Rate	Sig. Dif.	NYS Rate exc NYC	Sig. Dif.	Quartile	HP 2010 Goal	HP 2010 Goal Met?
CARDIOVASCULAR DISEASE									
Mortality rates per 100,000 (ICD10 I00-I99) <i>Crude</i>	15,965	397.3	358.6	Yes	369.8	Yes	3rd	N/A	N/A
Mortality rates per 100,000 (ICD10 I00-I99) <i>Age-adjusted</i>	15,965	339.2	341.1	No	331.5	Yes	3rd	N/A	N/A
Premature death (ages 35-64)	1,538	92.2	119.1	Yes	108.2	Yes	1st	N/A	N/A
Pretransport mortality	5,927	147.5	132.4	Yes	168.3	Yes	2nd	N/A	N/A
Hospitalization rates per 10,000 (ICD9 390-459) <i>Crude</i>	14,126	35.2	30.4	Yes	32.1	Yes	4th	N/A	N/A
Hospitalization rates per 10,000 (ICD9 390-459) <i>Age-adjusted</i>	14,126	30.1	29.5	Yes	29.3	Yes	4th	N/A	N/A
DISEASES OF THE HEART									
Mortality rates per 100,000 (ICD10 I00-I09, I11, I13, I20-I51) <i>Crude</i>	13,597	338.4	288.2	Yes	289.2	Yes	3rd	N/A	N/A
Mortality rates per 100,000 (ICD10 I00-I09, I11, I13, I20-I51) <i>Age-adjusted</i>	13,597	288.9	274.0	Yes	259.4	Yes	4th	N/A	N/A
Premature death (ages 35-64)	1,217	73.0	91.2	Yes	87.3	Yes	1st	N/A	N/A
Pretransport mortality	5,308	132.1	107.0	Yes	133.0	No	3rd	N/A	N/A
Hospitalization rates per 10,000 (ICD9 390-398, 402, 404-429) <i>Crude</i>	32,749	81.5	70.9	Yes	76.7	Yes	3rd	N/A	N/A
Hospitalization rates per 10,000 (ICD9 390-398, 402, 404-429) <i>Age-adjusted</i>	32,749	70.1	68.9	Yes	70.7	No	2nd	N/A	N/A
CORONARY HEART DISEASE									
Mortality rates per 100,000 (ICD10 I11, I20-I25)									
Crude	12,104	301.3	251.8	Yes	233.8	Yes	4th	N/A	N/A
Age-adjusted	12,104	256.9	239.4	Yes	209.6	Yes	4th	166	No
Premature death (ages 35-64)	1,070	64.2	81.9	Yes	70.3	Yes	1st	N/A	N/A
Pretransport mortality	4,948	123.1	95.5	Yes	110.9	Yes	3rd	N/A	N/A
Hospitalization rates per 10,000 (ICD9 402, 410-414, 429) <i>Crude</i>	32,749	81.5	70.9	Yes	76.7	Yes	3rd	N/A	N/A
Hospitalization rates per 10,000 (ICD9 402, 410-414, 429) <i>Age-adjusted</i>	32,749	70.1	68.9	Yes	70.7	No	2nd	N/A	N/A
CEREBROVASCULAR DISEASE (STROKE)									
Mortality rates per 100,000 (ICD10 I60-I69) <i>Crude</i>	1,384	34.4	40.4	Yes	52.2	Yes	1st	N/A	N/A
Mortality rates per 100,000 (ICD10 I60-I69) <i>Age-adjusted</i>	1,384	29.3	38.4	Yes	46.6	Yes	1st	48	Yes
Hospitalization rates per 10,000 (ICD9 430-438) <i>Crude</i>	14,126	35.2	30.4	Yes	32.1	Yes	4th	N/A	N/A
Hospitalization rates per 10,000 (ICD9 430-438) <i>Age-adjusted</i>	14,126	30.1	29.5	Yes	29.3	Yes	4th	N/A	N/A
- Behavior/Risk Indicator (2003) -	County Rate	CI #	NYS Rate	CI #	Upstate	CI #			
% of adults with diagnosis of heart attack, stroke, or angina	8.0	± 2.4	6.9	± 0.5	7.6	± 0.5	2nd	N/A	N/A
% of adults with cholesterol checked in the last 5 years	.		76.5	± 1.5	N/A	N/A	N/A	80	No
% of adults ever told they have high blood pressure	22.3	± 3.8	25.3	± 1.3	N/A	N/A	4th	16	No

*: Fewer than 20 events in the numerator; therefore rate is unstable, s: Total suppressed for confidentiality, #: 95% confidence interval for BRFSS/Expanded BRFSS indicators

Definition: Mortality rate is the number of deaths per 100,000 population. Hospitalization rate is the number of hospitalizations per 10,000 population. The standard population used for age adjustment was the 2000 US population. (BRFSS) % of respondents who reported they had been told by a health professional they had ever had a heart attack, stroke or angina in their lifetime. % of respondents who reported they had their cholesterol checked in the last 5 years. % of respondents who reported they had been told by a health professional they had high blood pressure.

Source: New York State Department of Health

**HIV/AIDS AND SEXUALLY TRANSMITTED DISEASES
NASSAU COUNTY
2000-2002**

Indicator	3 Year Total	County Rate	NYS Rate	Sig.Dif.	NYS Rate exc NYC	Sig.Dif.	Quartile	HP2010 Goal	HP2010 Goal Met?
HIV/AIDS									
AIDS case rate per 100,000	403	10.0	31.3	Yes	9.6	No	3rd	N/A	N/A
AIDS mortality rate per 100,000	131	3.3	11.1	Yes	3.1	No	3rd	N/A	N/A
AIDS mortality rate age-adjusted	131	3.1	11.0	No	3.1	No	3rd	N/A	N/A
HIV positive newborns rate per 1,000 tested (1999-2001)	43	0.9	3.4	Yes	1.2	Yes	3rd	N/A	N/A
SEXUALLY TRANSMITTED DISEASES									
Early Syphilis rate per 100,000	25	0.006	0.047	Yes	0.004	No	4th	N/A	N/A
Gonorrhea rate per 1,000									
-All Ages	1,391	0.3	1.1	Yes	0.8	Yes	3rd	N/A	N/A
- 15-19 years	371	1.5	4.5	Yes	3.5	Yes	3rd	N/A	N/A
Chlamydia rate per 1,000 Males									
-All Ages	640	0.3	0.7	Yes	0.5	Yes	2nd	N/A	N/A
-15-19 years	144	1.1	2.1	Yes	1.6	Yes	3rd	N/A	N/A
-20-24 years	225	2.0	3.2	Yes	2.8	Yes	3rd	N/A	N/A
Chlamydia rate per 1,000 Females									
-All Ages	1,935	0.9	2.7	Yes	1.6	Yes	1st	N/A	N/A
-15-19 years	692	5.7	15.5	Yes	10.3	Yes	1st	N/A	N/A
-20-24 years	718	7.1	14.3	Yes	9.5	Yes	2nd	N/A	N/A
Pelvic inflammatory disease (PID) hospitalization rate per 10,000 women ages 15-44 years	415	5.2	7.2	Yes	5.3	No	3rd	N/A	N/A

*: Fewer than 20 events in the numerator; therefore rate is unstable, s: Total suppressed for confidentiality

Definition:

AIDS Mortality: Information on deaths is extracted from death certificates. Each death receives an ICD-10 code indicating the primary cause of death. The codes for AIDS are ICD-10 codes: B20-B24. The mortality rates are per 100,000 population. Both crude and adjusted rates are presented. The standard population used for adjustment was the 2000 US population.

AIDS Case Rate: Information on AIDS cases comes from the NYS AIDS Case Surveillance Registry. AIDS case rates are presented as rates per 100,000 population. **

Newborn HIV Seropositive Rate: The New York State Department of Health tests specimens from the Newborn Screening Program for HIV antibodies. The seropositive rate is the number of positive results per 1,000 tested. The presence of HIV antibodies in newborns indicates infection of the mother and not necessarily infection of the infant.

Syphilis, Gonorrhea and Chlamydia: Early Syphilis includes any of the first three stages of syphilis (primary, secondary or latent of less than 1 year duration). Rates for syphilis are rates per 100,000 population. Gonorrhea and chlamydia are rates per 1,000 population in the particular age and sex grouping.

The number of hospitalizations with a primary diagnosis of Pelvic Inflammatory Disease (PID) per 10,000 women ages 15-44 years using the following ICD-9 codes: 098.10, 098.16, 098.17, 098.30, 098.36-098.37, 098.39, 098.86, 614.0-614.5, 614.7- 614.9, 615.0, 615.4, 615.9.

Data notes:

(See previous)

** The standard population used for age adjustment was the 2000 US population.

Source: New York State Department of Health

**INFECTIOUS DISEASES AND IMMUNIZATION
NASSAU COUNTY
2000-2002**

Indicator	3 Year Total	County Rate	NYS Rate	Sig.Dif.	NYS Rate exc NYC	Sig.Dif.	Quartile	HP2010 Goal	HP2010 Goal Met?
Pneumonia/flu hospitalizations in adults 65+ years per 10,000 (ICD9 480-487)	11,168	184.6	184.6	No	188.7	Yes	2nd	N/A	N/A
Measles incidence per 100,000	s	0.0*	0.1	No	0.0	No	2nd	0.0	Yes
Rubella incidence per 100,000	s	0.0*	0.0	No	0.0	No	2nd	0.0	Yes
Pertussis incidence per 100,000	25	0.6	2.0	Yes	3.0	Yes	1st	N/A	N/A
H. Influenza incidence per 100,000	34	0.8	0.9	No	1.0	No	2nd	0.0	No
Hepatitis A incidence per 100,000	149	3.7	4.1	No	2.4	Yes	4th	4.5	Yes
Hepatitis B incidence per 100,000	61	1.5	N/A	N/A	1.3	No	3rd	N/A	N/A
Tuberculosis incidence per 100,000	229	5.7	8.5	Yes	3.6	Yes	4th	1.0	No
E. Coli incidence per 100,000	40	1.0	1.2	No	2.0	Yes	2nd	N/A	N/A
Salmonella incidence per 100,000	605	15.1	14.5	No	13.0	Yes	3rd	N/A	N/A
Shigella incidence per 100,000	567	14.1	6.3	Yes	5.2	Yes	4th	N/A	N/A
Lyme disease incidence per 100,000	216	5.4	25.0	Yes	41.3	Yes	3rd	9.7	Yes
- Behavior/Risk Indicator (2003) -	County Rate	CI #	NYS Rate	CI #	Upstate	CI #			
% of adults 65+ years with flu shot in last year	72.3	± 8.7	68.0	± 64.2	N/A	N/A	3rd	90.0	No
% of adults 65+ years that ever received pneumonia shot	72.1	± 8.6	61.7	± 58.3	N/A	N/A	3rd	N/A	N/A

*: Fewer than 20 events in the numerator; therefore rate is unstable,

s: Total suppressed for confidentiality,

#: 95% confidence interval for BRFSS/Expanded BRFSS indicators

Definitions:

The number of hospitalizations for pneumonia and flu among persons ages 65 or older per 10,000 population in this age group. The ICD-9 codes included are: 480-487.

Rates are the number of reported cases of a disease per 100,000 population..

Tuberculosis rates exclude prison inmates.

The percent of respondents age 65 or older who indicated they had had a flu vaccination in the past 12 months.

The percent of respondents age 65 or older who indicated they had a pneumococcal pneumonia vaccination in their lifetime.

Data notes:

(See previous)

Source: New York State Department of Health

Exhibit 7CHAI 10

INJURY MORTALITY AND MORBIDITY NASSAU COUNTY 2000-2002

Indicator	3 Year Total	County Rate	NYS Rate	Sig.Dif.	NYS Rate exc NYC	Sig.Dif.	Quartile	HP 2010 Goal	HP 2010 Goal Met?
Suicide Mortality Rate per 100,000- <i>Crude</i>	213	5.3	6.7	Yes	7.6	Yes	1st	N/A	N/A
Suicide Mortality Rate per 100,000- <i>Age-Adjusted</i>	213	5.2	6.6	Yes	7.4	Yes	1st	N/A	N/A
Suicide Mortality Rate per 100,000-Ages 15-19 years	11	4.4*	5.5	No	6.6	No	2nd	N/A	N/A
Self-Inflicted Injury Hospitalization Rate per 10,000									
- <i>Crude</i>	1,644	4.1	4.4	Yes	5.0	Yes	1st	N/A	N/A
- <i>Age-Adjusted</i>	1,644	42.9	44.2	No	50.3	Yes	2nd	N/A	N/A
-Ages 15-19 years	252	10.1	9.8	No	10.8	No	2nd	N/A	N/A
Homicide Mortality Rate per 100,000- <i>Crude</i>	101	2.5	5.1	Yes	2.9	No	3rd	N/A	N/A
Homicide Mortality Rate per 100,000- <i>Age-Adjusted</i>	101	2.7	5.1	Yes	3.0	No	3rd	3.0	Yes
Assault Hospitalization Rate per 10,000- <i>Crude</i>	762	1.9	3.7	Yes	1.9	No	4th	N/A	N/A
Assault Hospitalization Rate per 10,000-Age-Adjusted	762	20.8	37.2	Yes	19.2	Yes	4th	N/A	N/A
Unintentional Injury Mortality Rate per 100,000- <i>Crude</i>	922	22.9	21.7	No	26.4	Yes	1st	N/A	N/A
Unintentional Injury Mortality Rate per 100,000- <i>Age-Adj.</i>	922	21.8	21.2	No	25.4	Yes	1st	N/A	N/A
Unintentional Injury Hospitalization Rate per 10,000									
- <i>Crude</i>	24,172	60.2	55.2	Yes	58.3	Yes	3rd	N/A	N/A
- <i>Age-Adjusted</i>	24,172	552.2	539.6	Yes	550.3	No	2nd	N/A	N/A
- <10 years	1,006	18.9	23.7	Yes	18.9	No	3rd	N/A	N/A
- 10-14 years	535	18.8	21.3	Yes	19.2	No	2nd	N/A	N/A
- 15-24 years	1,468	31.8	27.9	Yes	28.3	Yes	3rd	N/A	N/A
- 25-64 years	7,604	35.6	36.7	Yes	36.1	No	2nd	N/A	N/A
- 65+ years	13,559	224.1	210.9	Yes	230.0	Yes	2nd	N/A	N/A
Motor Vehicle Mortality Rate per 100,000- <i>Crude</i>	358	8.9	8.4	No	10.7	Yes	2nd	N/A	N/A
Motor Vehicle Mortality Rate per 100,000-Age-Adjusted	358	8.8	8.3	No	10.6	Yes	2nd	9.2	Yes
Non-Motor Vehicle Mortality Rate per 100,000									
- <i>Crude</i>	564	14.0	13.3	No	15.8	Yes	2nd	N/A	N/A
- <i>Age-Adjusted</i>	564	13.1	12.9	No	14.9	Yes	2nd	20.8	Yes
Traumatic Brain Injury Hospitalization Rate per 10,000									
- <i>Crude</i>	4,195	10.4	7.9	Yes	8.2	Yes	4th	N/A	N/A
- <i>Age-Adjusted</i>	4,195	103.4	78.2	Yes	80.1	Yes	4th	N/A	N/A
Work Related Injury Mortality Rate per 100,000 (Crude)	8	0.4*	0.6	No	0.9	No	2nd	N/A	N/A
Alcohol Related Motor Vehicle Injuries and Deaths per 100,000	1,982	4.9	4.9	No	7.0	Yes	1st	N/A	N/A

*: Fewer than 20 events in the numerator; therefore rate is unstable, s: Total suppressed for confidentiality

Data notes:

(See previous)

Source: New York State Department of Health

**MATERNAL AND INFANT HEALTH
NASSAU COUNTY
2000-2002**

Indicator	3 Year Total	County Rate	NYS Rate	Sig.Dif.	NYS Rate exc NYC	Sig.Dif.	Quartile	HP 2010 Goal	HP 2010 Goal Met?
% of births to women 25+ years w/out H.S. education	2,134	5.0	8.6	Yes	4.9	No	3rd	N/A	N/A
% births to out of wedlock mothers	9,213	18.6	36.6	Yes	28.6	Yes	1st	N/A	N/A
% first births	19,306	39.0	41.5	Yes	39.3	No	3rd	N/A	N/A
% of births that were multiple births	2,394	4.8	3.7	Yes	3.9	Yes	4th	N/A	N/A
% births w/early prenatal care	41,545	85.3	73.1	Yes	77.6	Yes	4th	90	No
% births w/late or no prenatal care	1,200	2.5	6.2	Yes	5.0	Yes	1st	N/A	N/A
% adequate prenatal care (Kotelchuck)	35,755	74.5	62.1	Yes	68.2	Yes	2nd	90	No
% Caesarian (Cesarean) section	15,087	30.5	26.1	Yes	27.2	Yes	4th	N/A	N/A
% Repeat Caesarian (Cesarean) section	6,104	12.3	9.8	Yes	11.0	Yes	4th	N/A	N/A
Mortality Rates (per 1,000 births)									
- Infant (<1 year)	260	5.3	6.0	Yes	6.1	Yes	2nd	4.5	No
- Neonatal (<28 days)	189	3.8	4.2	No	4.3	No	2nd	2.9	No
- Postneonatal (1 month to 1 year)	71	1.4	1.8	No	1.7	No	2nd	1.5	Yes
- Fetal death (>20 weeks gest)	232	4.4	7.2	Yes	5.4	Yes	1st	4.1	No
- Perinatal (20 wks gest - 28 days of life)	421	8.0	11.2	Yes	9.6	Yes	1st	N/A	N/A
- Perinatal (28 wks gest - 7 days of life)	275	5.3	6.3	Yes	6.1	Yes	2nd	4.5	No
Maternal mortality per 100,000 births	5	10.1*	16.3	No	7.2	No	4th	3.3	No
% low birthweight (<2.5 Kg)	3,748	7.6	7.8	No	7.3	Yes	3rd	5	No
% low birthweight singleton births	2,459	5.0	5.8	Yes	5.1	No	2nd	N/A	N/A
% Premature Births - <32 weeks gestation	799	1.6	2.0	Yes	1.9	Yes	1st	1	No
% Premature Births - 32 - 36 weeks gestation	4,603	9.4	9.5	No	9.0	Yes	4th	6.4	No
% Premature Births - <37 weeks gestation	5,402	11.0	11.5	Yes	10.9	No	3rd	7.6	No
% births w/5 minute APGAR <6	4,270	8.6	12.0	Yes	15.8	Yes	1st	N/A	N/A
% of births w/complications during labor & delivery	32,345	65.4	57.7	Yes	52.4	Yes	4th	20	No
Neonatal drug related discharge rate per 10,000 births	119	24.0	54.6	Yes	47.7	Yes	3rd	N/A	N/A

*: Fewer than 20 events in the numerator; therefore rate is unstable, s: Total suppressed for confidentiality

Definition:

The number of out of wedlock births is imputed by examining statistical information on the certificate of live birth. Also included in the calculation of out of wedlock births is any birth with a paternity affidavit filed.

Only the first of multiple births is considered a first time birth

The percent of total births to women who began prenatal care within the first three months of pregnancy (first trimester).

The percent of total births to women who began prenatal care within the last 3 months of pregnancy (3rd trimester) or not at all.

The percentage is based on the Kotelchuk Index. Births to women who began care in the first trimester and have completed at least 80% of the expected prenatal visits are considered to have had early and adequate care. *

Data notes:

***Kotelchuk Index:** The Kotelchuk Index is an adequacy of prenatal care index that takes into account the number of prenatal care visits received and number of expected by age of gestation at delivery, and incorporates a category that distinguishes women who have had more prenatal visits than would be expected (Adequacy Plus Category).

Source: New York State Department of Health

**RESPIRATORY DISEASES
NASSAU COUNTY
2000-2002**

Indicator	3 Year Total	County Rate	NYS rate	Sig. Dif.	NYS Rate exc NYC	Sig. Dif.	Quartile	HP 2010 Goal	HP 2010 Goal Met?
CLRD (COPD) mortality rate per 100,000									
<i>Crude</i>	1,313	32.7	34.4	No	46.1	Yes	1st	N/A	N/A
<i>Age-Adjusted</i>	1,313	27.6	33.1	Yes	41.6	Yes	1st	N/A	N/A
COPD (CLRD) hospitalization rate per 10,000									
<i>Crude</i>	6,255	15.6	17.4	Yes	19.5	Yes	1st	N/A	N/A
<i>Age-Adjusted</i>	6,255	13.3	16.9	Yes	18.0	Yes	1st	N/A	N/A
Asthma Hospitalization rates per 10,000									
Total Population - <i>Crude</i>	5,366	13.4	20.5	Yes	11.5	Yes	4th	N/A	N/A
Total Population - <i>Age-adjusted</i>	5,366	13.3	20.8	Yes	11.5	Yes	4th	N/A	N/A
0-4 years	1,202	47.9	66.0	Yes	35.7	Yes	4th	25.0	No
0-17 years	2,008	20.6	31.8	Yes	15.8	Yes	4th	17.3	No
5-64 years	3,129	9.9	16.3	Yes	9.0	Yes	4th	7.7	No
65+ years	1,035	17.1	24.7	Yes	15.0	Yes	3rd	11.0	No
Asthma mortality rate per 100,000 <i>Crude</i>	37	9.2	17.7	Yes	11.4	No	2nd	N/A	N/A
Asthma mortality rate per 100,000 <i>Age-Adjusted</i>	37	8.2	17.3	Yes	10.7	No	2nd	N/A	N/A
- Behavior/Risk Indicator (2003) -	County Rate	CI #	NYS Rate	CI #	Upstate	CI #			
% of adults with current asthma	6.3	± 2.3	7.9	± 0.6	7.9	± 0.6	1st	N/A	N/A

*: Fewer than 20 events in the numerator; therefore rate is unstable, s: Total suppressed for confidentiality, #: 95% confidence interval for BRFSS/Expanded BRFSS indicators

Definitions:

The prevalence of currently diagnosed asthma was based on answers to two questions: 1) Did a health professional tell you that you had asthma? and 2) Do you still have asthma?

Mortality: Data are collected from death certificates. All deaths receive an ICD-10 code indicating the primary reason for the death. The ICD-10 codes used for the rates in this section are as follows: **asthma** : codes J45-J46, **Chronic Lower Respiratory Disease (CLRD)**: codes J40-J47. The mortality rates are rates per 100,000 persons. **

The number of hospitalization per 10,000 with a primary diagnosis, using the following ICD-9 codes: **Asthma**: code 493; **Chronic Obstructive Pulmonary Disease (COPD)**: codes 490-494,496. **

Data notes:
(See previous)

** The standard population used for age adjustment was the 2000 US population.

Source: New York State Department of Health

APPENDIX 8 – NEW YORK STATE DEPARTMENT OF HEALTH DATA RESOURCES

Public health data sets relating to counties or specific health issues can be accessed through the NYSDOH website: http://www.health.state.ny.us/nysdoh/chac/nysdoh_program_data.htm

AIDS/HIV	AIDS Surveillance Quarterly Updates and AIDS in New York State Reports. Has data at the state and regional levels
Behavioral Risk Factor Surveillance System (BRFSS) Reports	State-level adult behavior risk survey finding relating to physical activity, oral cancer risks, fetal alcohol syndrome, skin cancer, diabetes, among others.
Communicable disease statistics	Reported cases, and rates of communicable diseases by county and in New York State.
Community Health Data Set	Series of tables, maps and graphs containing health statistics for 18 health-related data categories organized by county of residence. Most of the indicators are presented via a 3-year table (T), table+10-year trend plots (T+TR, to access a trend chart, click on the highlighted county name in the 3-year table), bar chart/map (M), and trend graph (G). Tables show, where possible, the last 3 years of information for County, Region, and New York State. Maps highlight the top 5 and bottom 5 counties for each indicator.
County Health Indicator Profile	Selected county-level indicators relating to socio-demographic, perinatal health, mortality, hospitalizations, and disease morbidity.
Cancer	Cancer Incidence by zip-code, cancer booklets, and county-level maps
Health care utilization <ul style="list-style-type: none">- Managed Care Reports- Medicaid Statistics	Data on quality of managed care plans in New York State. Medicaid reports/profiles by demographic group and by county.
Hospital discharge data/ SPARCS annual report	Each SPARCS Annual Report contains a narrative, appendices, and standardized statistical tables. The narrative describes the background of SPARCS, the data sources for the report, and the data displayed. The statistical tables include discharges, patient days, and average length of stay data aggregated by age, sex, expected primary source of reimbursement, service category, disposition of patient, county of residence/hospitalization, discharge rate, federal DRG, average total charge of stay, principal diagnostic categories, surgical procedure categories, federal MDC, and total length of stay
Lead	County-level and selected zip-code level data on incidence of elevated blood lead levels in children under six years.
Vital Statistics	1997, 1998 and 1999 data: state and county-level data relating to population, live births, pregnancies, and fetal deaths, mortality. Profiles for cities and villages with populations greater than 15,000.

APPENDIX 9 - NEW YORK STATE PARTNER DATA RESOURCES

Kids Well-being Indicators' Clearinghouse (KWIK)	User-friendly, and queriable; county-specific, children's health, education and well-being indicators utilized by New York States' health and human services agencies. The indicators are based on the <u>Council on Children and Families Touchstones/KidsCount Data Book</u> . <u>New York State Chartbook of Mental Health Information</u> : The 2000 edition of the chartbook is a comprehensive look at the system; it includes demographics, client characteristics, service work-load, expenditures, and revenues.
NYS Council on Children and Families Touchstones/KIDS Count	Touchstones is a tool to help guide local efforts on improving outcomes for children. The Touchstone Databook is a compilation of children's well-being indicator data based on the six areas in which New York State aims to improve the lives of its children (i.e. economic security, physical and emotional health, education, citizenship, family and community). Data was collected as part of the Annie E. Casey's Kids Count project. The data will be accessible through the Kids's Well-being Indicator Clearinghouse (KWIC).
New York State Data Center	Provides population estimates by county, town, village, and city; county migration data, state and county economic census data; and county business pattern data. It also provides links to other data sources.
New York State Department of Labor	Has a wealth of state, county, region, and MSA labor statistics, including employment and unemployment statistics, employment by sector, recent labor market trends, earnings, occupational projections, and a directory of labor market information.
NYS Department of Education	The school report cards and statistical reports provide useful data by school and school district, including performance and accountability measures (regent test score results), enrollment, demographics (e.g. race/ethnicity), drop-out and attendance rates, and students enrolled in school lunch program.
NYS Office of Real Property Services Municipal Profiles	Provides school, property sales and tax information by county and municipality.
PRISMS: Prevention Risk Indicator Services Monitoring System	Is a data warehouse from the New York State Office of Alcohol and Substance Abuse Services (OASAS) data warehouse for community-level information for alcohol and substance abuse services. Has information on 62 risk indicators and ten consequences indicators is provided in tables organized under three general domains for each county: community risk, youth risk and early consequences of alcohol and substance Abuse (ASA). Risk indicators are individual measures of a risk factor that are combined into risk constructs. Consequences indicators are measures of problems youth are experiencing as a result of ASA use.

APPENDIX 10 - NATIONAL PUBLIC HEALTH DATA RESOURCES

American FactFinder	Accesses data from the Censuses of Population and Housing, the American Community Survey, and the Economic Census. Users can search Census STF databases, with metadata description, and format the results to create customized tables (or download to spreadsheets), construct reference maps to show boundaries and features for geographic entities, and produce quick thematic maps to reveal geographic patterns in statistical data.
Anne E. Casey Foundation	Has links to KIDS COUNT, a project of the Annie E. Casey Foundation. This is a national and state-by-state effort to track the status of children in the United States.
Behavioral Risk Factor Surveillance System	(BRFSS): State-level data on adult substance use, tobacco use, diet and other preventive health practices and risk behaviors that are linked to chronic diseases, injuries and preventable infectious diseases. County-level synthetic data estimates for selected risk indicators may be accessed by local health departments.
Child Health USA 2000	Amasses secondary data on health status and service needs of children. Report provides over 50 health status indicators and includes information on infants, children, and adolescents, health service utilization, state-specific and local data, as well as information on the nation's progress towards meeting the Healthy People objectives.
Child Trends	Has national trends and research data on over 70 key indicators of child and youth well-being including demographic, health, social and emotional development, income-assets and work, education and skills, and family and community.
Children's Defense Fund	Has data and information related to child poverty, education, and child care costs.
Federal Interagency Council on Statistical Policy	More than 70 agencies in the U.S. Federal Government produce statistics of interest to the public. This site provides easy access to the full range of county- and state-level statistics and information produced by these U.S. government agencies for public use. Among the postings are county level data on immigration, crime, and poverty estimates.
Healthy People 2000	The Healthy People 2000 main web site describes the overall agenda for achievement of national health objectives, priority areas, progress to date, lead agencies, data sources, publications, and more.
Healthy People 2010	<i>Healthy People 2010</i> released in January, 2000 presents 467 objectives to improve the health of Americans by the year 2010. It is a statement of national health objectives designed to identify the most significant preventable threats to health and to establish national goals to reduce these threats. Background information and the entire HP 2010 document are available online.
Kids Count	Has data and information on child well-being indicators. Also links to state Kids Count Data publications.

National Survey of America's Families	Provides a comprehensive look at the well-being of adults and children and reveals sometimes striking differences among the 13 states studied in depth. The survey pays particular attention to low-income families, and reporting on important aspects about their lives and how they differ from the lives of children and adults in families with higher incomes. It is a part of New Federalism, a multi-year research project of the Urban Institute. The survey is representative of the non-institutionalized, civilian population of persons under age 65 in the nation as a whole and in 13 states, including Massachusetts and New York. Site visitors can retrieve and download survey results.
Peristats	PeriStats is an interactive perinatal data resource developed by the March of Dimes that provides maternal, infant and child health-related data with state-level and some county-level indicators.
State Health Facts Online	A resource developed by Kaiser Family Foundation contains the latest state-level data on demographics, health, and health policy, including health coverage, access, financing, and state legislation.
United Way State of Caring Index	Measures the health and well-being at the state and national levels using 32 social and economic indicators in six key areas: Economic and financial well-being; Education; Health; Voluntarism/Charity/Civic Engagement; Safety; Natural Environment and Other factors.
Youth Risk Behavior Surveillance System (YRBS)	State-level and New York City data by gender in six categories of health-risk behaviors. These include: unintentional and intentional injuries; tobacco use alcohol and other drug use; sexual behavior; unhealthy dietary behavior and physical activity.

APPENDIX 11 – GLOSSARY

Access to health care	“The timely use of personal health services to achieve the best possible outcomes.” It can include, but is not limited to, availability of information, care, public or private insurance coverage, transportation, culturally and linguistically competent care, and other factors that affect personal and cultural decisions related to seeking health care services. (IOM)
Abortion Ratio	Annual number of induced abortions per 1,000 live births occurring during the year. (NYSDOH)
Age	The number of complete years an individual has lived. The age classification is based on the age of the person at his or her last birthday. (US Census)
Age-Adjusted Death Rate	Death rate of a group calculated as a weighted average of the age specific death rate of the same group. The age distribution of a population for a given period of time is called the standard population. In this report the standard population is the census count of the United States in 2000. . (US Census)
AIDS Case Rate (Other)	Cumulative number of AIDS cases from the AIDS Case Registry for other than (MSM) men who have sex with men (intravenous drug use cases, heterosexual contact cases) aged 15-54 per 100,000 population aged 15-54. (NYSDOH AIDS Institute Community Need Index)
Asian	A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. (US Census 2000)
Baby Boom	People born during 1946 to 1964 (post-WWII) are referred to as "baby boomers" or the baby-boom generation. (US Census)
Birth Rate	The average annual number of births during a year per 1,000 population. Also know as the crude birth rate. (NYSDOH)
Black (or African American)	A person having origins in any of the black racial groups of Africa. Over time, the terminology used for this race category has included Black, Negro, and African American. It includes written entries such as African American, Afro American, Kenyan, Nigerian, Haitian or Caribbean American. (US Census 2000)
Cocaine Discharge Rate	Average of three years cocaine-related hospital discharges for persons aged 15-54 per 100,000 population aged 15-54. (NYSDOH AIDS Institute Community Need Index)
Crude Birth Rate	<i>See Birth Rate</i>
Family	A group of two or more people who reside together and who are related by birth, marriage, or adoption. (US Census)
Family Household	A family household consists of a householder and one or more people living together in the same household who are related to the householder by birth, marriage, or adoption. All people in a household who are related to the householder are regarded as members of his or her family. people not related to the householder are not included as part of the householder's family in census tabulations. In 1950 and 1960, a household enumerated in the census could contain more than one family. Thus, there were more families than family households. From 1970 to 2000, each family household in the census could contain only one family, resulting in an equal number of families and family households. (US Census)

Female Householder, No Husband Present	A woman maintaining a family household with no husband of the householder present. (US Census)
Fertility Rate	Annual number of live births per 1,000 female population, aged 15-44. (NYSDOH)
Haemophilus influenzae (Hib)	Haemophilus influenzae type b or Hib - A gram-negative, rod-shaped bacterium of the genus <i>Haemophilus</i> that occurs in the human respiratory tract and causes acute respiratory infections, acute conjunctivitis, and purulent meningitis; type b is the most common pathogenic form of the bacterium. It is very serious and usually strikes children under 5 years old. (CDC)
Head of Household	<i>See Householder</i>
Health Insurance Coverage	<p>A person is considered covered by health insurance at some time during the year if he or she was covered by at least one of the following types of coverages:</p> <ol style="list-style-type: none"> 1. Employment/union 2. Privately purchased (not related to employment) 3. Medicare 4. Medicaid 5. Military health care (military, CHAMPUS, CHAMPVA, VA, Indian Health Services) 6. Someone outside the household 7. Other <p>An individual can have more than one type of coverage during the year. (US Census)</p>
Hispanic or Latino Origin	People who identify with the terms <i>Hispanic</i> or <i>Latino</i> are those who classify themselves in one of the specific Hispanic or Latino categories listed on the decennial census questionnaire-"Mexican, Mexican-Am, Chicano, "Puerto Rican," or "Cuban"-as well as those who indicate that they are "other Spanish Hispanic, or Latino." Origin can be viewed as the heritage, nationality group, lineage, or country of birth of the person or the person's parents or ancestors before their arrival in the United States. People who identify their origin as Spanish, Hispanic, or Latino may be of any race. (US Census 2000)
HIV Discharge Rate (female)	Average of three years HIV-related hospital discharges for females aged 15-54 per 100,000 female population aged 15-54. (NYSDOH AIDS Institute Community Need Index)
HIV Discharge Rate (male)	Average of three years HIV-related hospital discharges for males aged 15-54 per 100,000 male population aged 15-54. (NYSDOH AIDS Institute Community Need Index)
Household	One person or a group of people living in a housing unit. (US Census)
Housing Unit	A housing unit is a house, an apartment, a mobile home, a group of rooms, or a single room that is occupied or intended for occupancy, as separate living quarters. Separate living quarters are those in which the occupant(s) live separately from any other people in the building and which have direct access from outside the building or through a common hall. (US Census)
Infant Mortality Rate	The number of deaths to infants less than 1 year of age occurring during the year per 1,000 births. (NYSDOH)
LHD	Local health department (Nassau County Department of Health)

Life Expectancy at Birth	The average number of years a hypothetical group of people born in a specified year would live if they experienced over their lifetime the mortality rates at each year of age that occurred in the specified year (e.g., 1900 or 2000). (US Census)
Low Birthweight (LBW)	Live births with birthweight less than 2,500 grams.
Median Age	The median divides the age distribution into two equal parts, one-half of the population falling below the median age and one-half above the median. (US Census)
Morbidity	The prevalence of a disease in a population.
Mortality rate	The ratio of deaths in an area to the population of that area, can be <i>crude</i> or <i>age-adjusted</i> .
MSM Case Rate	Cumulative number of AIDS cases (for a specific period of time) for men who have sex with men aged 15-54 per 100,000 male population aged 15-54. (NYSDOH AIDS Institute Community Need Index)
Newborn Seroprevalence	Since 1987, all newborns in NYS have been tested anonymously for the presence of HIV antibody. HIV antibody in newborns indicates that the mothers of these babies are infected. (NYSDOH AIDS Institute Community Need Index)
NPHPSP	National Public Health Performance Standards Program.
Opioid Discharges	Average of three years opioid-related hospital discharges for persons aged 15-54 per 100,000 population aged 15-54. (NYSDOH AIDS Institute Community Need Index)
Per Capita Income	The per capita income for an area is defined as the total personal income in an area, divided by the number of people in that area. The Census Bureau derived per capita income by dividing the total income of a particular group by the total population in that group (excluding patients or inmates in institutional quarters).
Pertussis	Also known as whooping cough , is a highly contagious disease that is one of the leading causes of vaccine-preventable deaths. There are 30-50 million cases per year, and about 300,000 deaths per year. Virtually all deaths occur in children under one year of age. 90% of all cases occur in developing countries. It is caused by certain species of the bacterium <i>Bordetella</i> - usually <i>B. pertussis</i> , but some cases are caused by <i>B. parapertussis</i> .
Pregnancy Rate	Annual number of pregnancies per 1,000 female population aged 15-44. (NYSDOH)
Prevention	An active process that promotes the personal, physical and social well-being of individuals and families to reinforce positive health behaviors and lifestyles that minimize morbidity and maximize the overall quality of life. Primary care can be viewed as a form of prevention as its proper use can result in fewer hospitalizations for conditions such as asthma, diabetes, chronic obstructive pulmonary disease, and congestive heart failure, which are affected by the level of care given on an outpatient basis. (CDC)
Population Projections	A calculation of population size derived for future dates using assumptions about future trends and data from population censuses, administrative records, sample surveys, and/or other sources. (US Census)

Race	As per the U.S. Census, prior to 1980, race was determined either solely by the observation of the enumerator or by a combination of enumerator observation and self-identification. These categories reflect social usage and should not be interpreted as being scientific or anthropological in nature. Furthermore, the race categories include both racial and national-origin groups.
Rubella	A mild contagious eruptive disease caused by a virus and capable of producing congenital defects in infants born to mothers infected during the first three months of pregnancy. Also called German measles. (CDC)
Sexually Transmitted Disease (STD)	Syphilis, gonorrhea or chlamydia.
Standard Population	The age distribution of a population for a given period of time
Teenage Birth Rate	Annual number of live births to women aged 15-19 per 1,000 female population aged 15-19.
Teen Pregnancy Rate	Annual number of pregnancies to women aged 15-19 per 1,000 female population aged 15-19.
White	A person having origins in any of the original peoples of Europe, the Middle East, or North Africa. It includes people who indicate their race as <i>White</i> or reports entries such as Irish, German, Italian, Lebanese, Near Easterner, Arab or Polish.
WIC	Special Supplemental Program for WOMEN, INFANTS and CHILDREN.
Years of Life Lost (YLLs)	A measure of premature mortality. The measure subtracts the person's age at death from the life expectancy for someone that age in a standard population. The younger the age at death, the greater the Years of Life Lost. Since many younger deaths could be prevented or postponed this measure has implications for prevention efforts.

APPENDIX 12 - COMMENTS AND SUGGESTIONS FORM

Periodic updates are made to the Community Health Assessment. Your comments and suggestions are invited. Proposed changes should be submitted to:

Carolyn Ashe
Management Analyst
Nassau County Department of Health
240 Old Country Road, Room 513
Mineola, NY 11501
Phone: (516) 571-3344
Fax: (516) 571-1666
Email: Carolyn.Ashe@hhsnassaucountyny.us

Referenced section #, section part, name and page number: _____

A description of your proposed change:

Rationale (relate experiences, research, data, etc. that are the basis for your comment or suggestion).

Your name *(optional)*

Position *(optional)*

Organization *(optional)*

Mailing address *(optional)*

Phone *(optional)*

Fax *(optional)*

Date

Email *(optional)*

Attach additional pages if necessary.

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NASSAU COUNTY, NY

Albertson 11507

Searington

Atlantic Beach 11509

Atlantic Beach Estates

Baldwin 11510

Baldwin Harbor

Bayville 11709

Bellmore 11710

Bethpage 11714

Carle Place 11514

Cedarhurst 11516

East Meadow 11554

East Norwich 11732

East Rockaway 11518

Bay Park

East Williston 11596

Elmont 11003

Farmingdale 11735

Floral Park 11001

Bellerose Terrace, Floral Park

Centre, South Floral Park

Franklin Square 11010

Freeport 11520

Garden City 11530

Garden City South, Stewart

Manor

Glen Cove (city) 11542

Glen Head 11545

Brookville, Old Brookville

Glenwood Landing 11547

Great Neck 11020,11021, 11023, 11024

Great Neck Estates, Great Neck

Garden, Great Neck Plaza,

Harbor Hills, Kensington, Kings

Point, Lake Success, Russell

Gardens, Saddle Rock,

Thomaston, University Gardens

Greenvale 11548

Hempstead (village) 11550

Hewlett 11557

Hewlett Bay Park, Hewlett Harbor,

Hewlett Neck

Hicksville 11801

Inwood 11096

Island Park 11558

Barnum Island, Harbor Isle

Jericho 11753

Lawrence 11559

Levittown 11756

Locust Valley 11560

Lattintown

Matinecock

Long Beach (city) 11561

Lido Beach

Lynbrook 11563

Malverne 11565

Manhasset 11030

Flower Hill, Munsey Park,

Strathmore,

Massapequa 11758

East Massapequa, West Amityville

Massapequa Park 11762

Merrick 11566

Mill Neck 11765

Mineola 11501

New Hyde Park 11040

Garden City Park, Herricks

Oceanside 11572

Old Bethpage 11804

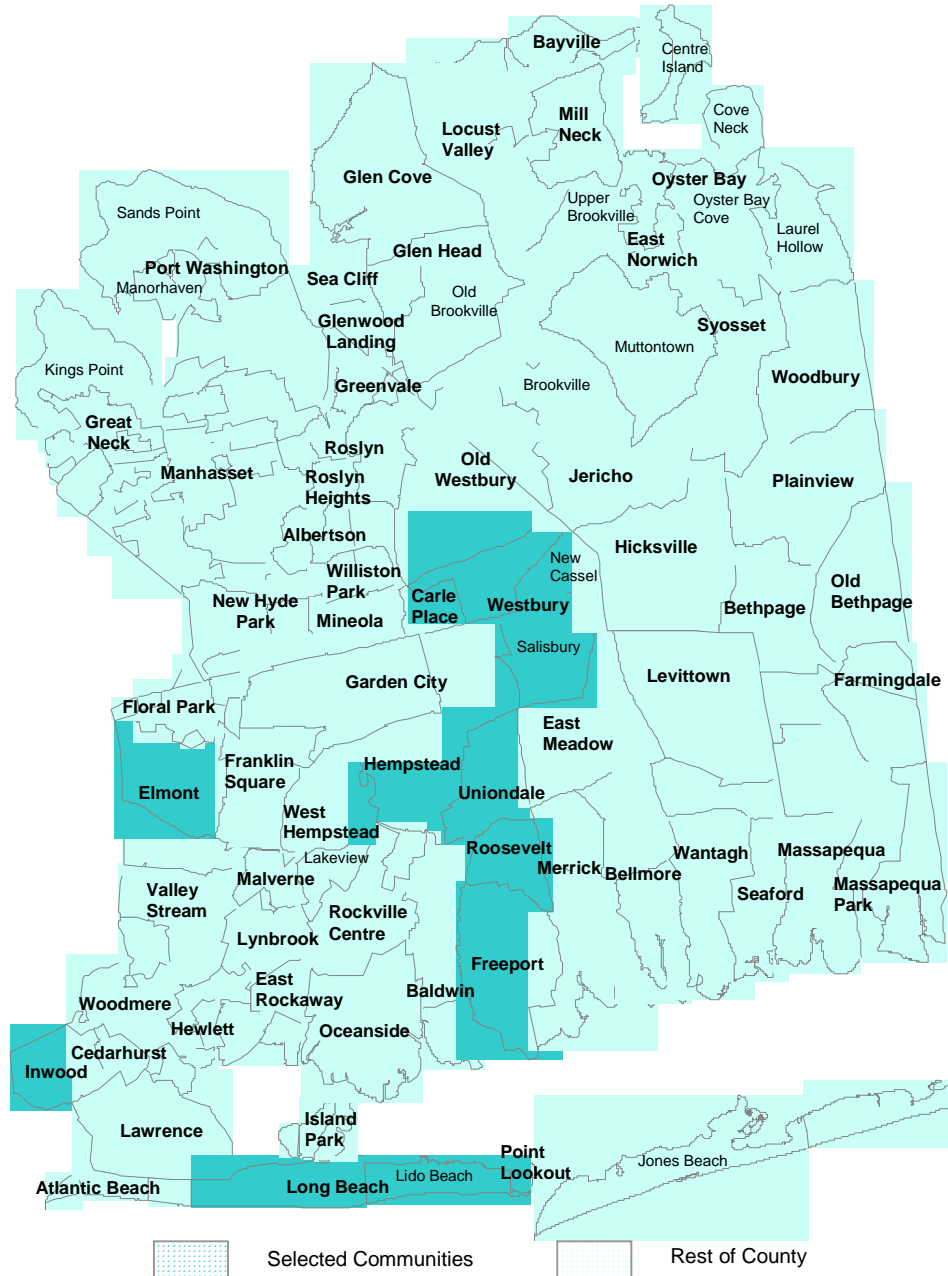
Old Westbury 11568

Oyster Bay (hamlet) 11771

Centre Island, Cove Neck , Oyster

Bay Cove, Plainedge, Upper

Brookville



Selected Communities



Rest of County

Plainview

11803

Point Lookout

11569

Port Washington

11050

Baxter Estates, Manorhaven, Port

Washington North, Sands Point

Rockville Centre

11570

Roosevelt

11575

Roslyn

11576

East Hills, Roslyn Estates, Roslyn

Harbor,

Roslyn Heights

11577

Sea Cliff

11579

Seaford

11783

Syosset

11791

Muttontown, Laurel Hollow,

Locust Grove

Uniondale

11553

Valley Stream

11580,11581

Wantagh

11793

West Hempstead

11552

Lakeview

Westbury

11590

New Cassel, Salisbury

Williston Park

11596

Woodbury

11797

Woodmere

11598

Woodsburgh



THOMAS R. SUOZZI
County Executive

NASSAU COUNTY LEGISLATURE

KEVAN ABRAHAMS
District 1
ROGER H. CORBIN
Deputy Presiding Officer
District 2
JOHN J. CIOTTI
District 3
DENISE FORD
District 4
JOSEPH SCANNELL
District 5
FRANCIS X. BECKER SR.
District 6

JEFFREY W. TOBACK
District 7
VINCENT T. MUSCARELLA
District 8
RICHARD J. NICOLELLO
District 9
LISANNE G. ALTMANN
District 10
CRAIG M. JOHNSON
District 11
PETER J. SCHMITT
Minority Leader
District 12
NORMA L. GONSALVES
District 13

DAVID MEJIAS
District 14
DENNIS DUNNE SR.
District 15
JUDITH A. JACOBS
Presiding Officer
District 16
EDWARD P. MANGANO
District 17
DIANE YATAURO
District 18
DAVID W. DENENBERG
District 19